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Kimberly McKittrick  
Mental Health Interventions for  
Homeless Young Children Through an  
Attachment Theory Lens: A Review and  
Analysis of the Literature

**ABSTRACT**

This thesis is a review and analysis of the literature on mental health interventions that may be effective for treating homeless young children living in emergency shelters or transitional housing. It begins with a discussion of family homelessness in the United States, and continues with a review of the literature on relationships among maternal mental health, children's mental health, and homelessness. While homelessness is associated with increased maternal mental illness, the association between homelessness and children's wellbeing appears to be mediated by the mother-child attachment relationship. Therefore, a discussion of attachment theory, attachment in homeless and impoverished children, and the implications of attachment for children's mental health follows. Several evidence-based mental health interventions for young children that focus on attachment relationships are reviewed, and their feasibility in homeless shelters or transitional housing discussed. This thesis concludes with a discussion of evidence-based practice and recommendations for policy, practice, and future research.

**Mental Health Interventions for Homeless Young Children**  
**Through an Attachment Theory Lens:**  
**A Review and Analysis of the Literature**

A project based upon a review and analysis of the literature,  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work.

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2018

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## TABLE OF CONTENTS

ACKNOWLEDGMENTS .....	ii
TABLE OF CONTENTS.....	iii
CHAPTER	
I. INTRODUCTION.....	1
II. FAMILY HOMELESSNESS IN THE UNITED STATES .....	6
III. FAMILY HOMELESSNESS AND MENTAL HEALTH .....	21
IV. ATTACHMENT THEORY AND RESEARCH.....	40
V. INTERVENTIONS .....	69
VI. DISCUSSION .....	132
REFERENCES .....	149

## **CHAPTER I**

### **Introduction**

When a clinical social worker sees a social problem that results in human suffering, her or his response will likely be, “How can I help?” The social problem at the heart of this thesis is family homelessness. The suffering experienced by children whose families become homeless takes many forms, including emotional and behavioral difficulties that may adversely shape their childhoods and adulthoods. The purpose of this thesis is to review and analyze the literature on mental health interventions that may be effective in addressing the needs of homeless infants and young children whose families are living in emergency shelter and transitional housing settings.

Family homelessness is a major social problem in the United States. Families with children make up 35% of people experiencing homelessness (Bassuk, DeCandia, Beach, & Berman, 2014; Henry et al., 2016). The vast majority of homeless families are composed of a single mother with two young children (Bassuk et al., 2014; Solari et al., 2016). In 2016, the U.S. Department of Housing and Urban Development (HUD) estimated that 481,410 people in families with children were homeless; 292,697 of them were children under the age of 18 (Henry et al., 2016). Of those children, 49.6% (145,178) were under six years old, and 10.7% (31,318) were infants under the age of one year (Solari et al., 2016). In 2016, approximately 90% of the people in homeless families were sleeping either in emergency shelters or transitional housing (Henry et al., 2016). Using a different count methodology from HUD, the U.S. Department of Education (DOED) conducts a yearly count of homeless children and youth enrolled in public

schools. In school year 2015–2016, DOED counted 1,304,803 homeless children and adolescents enrolled in grades K–12 and preschool (National Center for Homeless Education [NCHE], 2017). Extrapolating from HUD’s and DOED’s counts, a recent estimate placed the number of homeless children in the United States at nearly 2.5 million; this represents one in every 30 children in the country (Bassuk et al., 2014).

Homelessness has associations with maternal mental health, and maternal mental health is associated with children’s mental health. Rates of depression, anxiety, and PTSD are higher in homeless mothers than in low-income housed mothers, mothers in general, and women in general (Curtis, Corman, Noonan, & Reichman, 2014; Ertel, Rich-Edwards, & Koenen, 2011; Park, Fertig, & Metraux, 2011; Zabkiewicz, Patterson, & Wright, 2014). Maternal stress, due to depression and other mental illness, may lead to changes in the attachment patterns and brain structures of their young children that will interfere with the development of emotional regulation, cognitive skills, and social relationships (Bassuk et al., 2014). Within homeless families, maternal mental illness has been associated with children’s emotional and behavioral problems (Bassuk et al., 2014; Harpaz-Rotem, Rosenheck, & Desai, 2009).

The findings in studies of homeless families have been divided regarding a direct relationship between homelessness and children’s emotional and behavioral problems (Buckner, 2008; Harpaz-Rotem et al., 2009; Park, Fertig, & Allison, 2011). While homeless children have higher rates of mental health problems than their low-income housed counterparts, the differences reported are not consistently significant (Bassuk, Richard, & Tsertsvadze, 2015; Buckner, 2008). The Continuum of Risk Hypothesis proposes that homeless children are exposed to a greater variety of risk factors than other children, and are therefore more likely to experience the adversities that lead to emotional or behavioral difficulties (Buckner, 2008). Homeless

children are exposed to three types of risks: risks specifically related to homelessness (e.g., stresses related to losing possessions or living in a shelter); risks shared by children in low-income families (e.g., hunger, or exposure to community violence); and risks that all children share, regardless of family income (e.g., family dysfunction). While some children who are at risk for more types of adversity may not experience all of the possible types, those who are at risk for fewer types of adversity may experience adversities that prove more detrimental to their wellbeing. As one of the many risk factors that children living in poverty may face, homelessness is associated with other risks that affect children's emotional wellbeing (Brumley, Fantuzzo, Perlman, & Zager, 2015).

Some researchers have suggested that young children's responses to homelessness and other associated traumas and stresses may be mediated by attachment to their mothers or primary caregivers (Bassuk et al., 2015). *Attachment* describes the relationship that develops between a mother and young child during the child's first years of life (Bowlby, 1982). If the mother is sufficiently attuned and responsive to the child's needs and feelings, the child will develop a secure attachment. If the mother's responses to the child are inconsistent, rejecting, or frightening, the child may develop an insecure attachment. Within the context of secure attachment relationships, children learn to regulate their emotions and arousal, communicate their emotions and thoughts to others, and explore and learn, knowing that their mothers are available for comfort and support when needed. Children who have insecure attachments are more likely than securely attached children to struggle with emotional and behavioral regulation, particularly when they are separated from their mothers, as when they start school. Secure attachment in young children has been associated with lower rates of emotional and behavioral difficulties as children begin school and reach middle childhood (Keyser, Ahn, & Unick, 2017).



While no association has been found between homelessness and attachment security, poverty and risks associated with poverty have been associated with lower attachment security (Easterbrooks & Graham, 1999).

Providing mental health assessment for young homeless children and their mothers, and early intervention for those who need treatment, is vitally important. Low-income children have lower rates of secure attachment than their more advantaged counterparts (Easterbrooks & Graham, 1999). Research has established that children who experience homelessness have more mental health problems than their low-income housed counterparts (Buckner, 2008) and that attachment difficulties and mental health problems in early childhood are often associated with emotional, behavioral and educational problems that negatively affect the trajectory of children's lives (Keyser et al., 2017). Early intervention offers children the best opportunity for success as they grow and eventually build families of their own. Families with children who are living in emergency shelter or transitional housing settings are in regular contact with social workers and other service providers. The opportunity therefore exists to assess the children and their mothers, and to provide appropriate mental health treatment in those settings.

While one recent review of the literature on parenting interventions for homeless families exists (i.e, Haskett, Loehman, & Burkhart, 2014), to my knowledge, no literature reviews on clinical interventions for homeless children in shelter or transitional housing settings have been conducted. In preparing this literature review, three electronic databases (Web of Science, PsycINFO, and PubMed) were searched for articles published in peer-reviewed journals from 2000 to 2017, with search terms targeting literature reviews of mental health interventions for young homeless children. Searches were conducted using synonyms and combinations of the following terms: "literature review," "homeless," "child," "mental health," and "intervention."

Results included literature reviews concerning the mental health difficulties and needs of homeless children; interventions to address these needs were not addressed. This gap is not surprising, as few peer-reviewed studies of mental health interventions specifically for homeless children exist. This literature review is thus important for social work because it may identify interventions that can be used or adapted for use in clinical work with young homeless children in emergency shelter and transitional housing settings.

This thesis has six chapters. Chapter II is a discussion of family homelessness in the United States, including definitions of homelessness as they apply to children and families, the sociocultural characteristics of homeless families, and the types and characteristics of shelter available to homeless families. Chapter III contains a review of the literature on the relationships between maternal mental health and children's mental health, homelessness and maternal mental health, and homelessness and children's mental health. Chapter IV is a discussion of attachment theory, the relationships among attachment, homelessness, poverty, and trauma, and the implications of attachment for children's mental health and development. Chapter V reviews evidence-based, attachment-focused clinical interventions with young children and their parents that have been implemented in emergency shelter or transitional housing settings, or those developed for and studied with similar populations that might be used or adapted for use with homeless families in emergency shelter or transitional housing. Chapter VI is a discussion of evidence-based practice focused on the reviewed interventions, and recommendations for policy, practice, and future research.

## CHAPTER II

### Family Homelessness in the United States

The United States has had large numbers of homeless families only twice in its history: during the Great Depression, and from the early 1980s to today (Murphy & Tobin, 2014). The current period of family homelessness shows little sign of remitting. This chapter includes a discussion of federal definitions of homelessness that apply to families and children, approaches to counting homeless families and children, factors contributing to family homelessness, and shelter options available to homeless families. While HUD uses the term *homeless families with children* to distinguish them from homeless adult couples and homeless unaccompanied minors, for the purposes of this thesis, *homeless families* also means families composed of one or more adults and one or more children under the age of 18.

#### Defining Homelessness

Defining homelessness is fundamental to understanding family homelessness. The first federal definition of homelessness was written into the Stewart B. McKinney Homeless Assistance Act (McKinney Act, 1987), which funded a variety of services for homeless people, including emergency shelters and transitional housing, and provided assistance and protections for homeless schoolchildren. The McKinney Act defined a homeless individual as lacking “a fixed, regular, and adequate nighttime residence” and sleeping in a homeless shelter, an institution, or “a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings” (McKinney Act, 1987, 42 U.S.C. 11302 Sec. 103(a) ).

However, a single federal definition of homelessness no longer exists. In 2000, the McKinney Act was renamed the McKinney-Vento Homeless Assistance Act (McKinney-Vento, 2000). McKinney-Vento now contains two definitions of homelessness, one used by the U.S. Department of Housing and Urban Development (HUD), and the other by the U.S. Department of Education (DOED).

HUD uses the definition of homelessness contained in Section 103 of Subtitle I of McKinney-Vento, most recently amended by the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 (HEARTH Act). This definition includes four categories that describe an individual or family who “lacks a fixed, regular, and adequate nighttime residence” (HUD Definitions, 2012, p. 517):

1. An individual or family with a primary nighttime residence that is a place not intended as a sleeping accommodation for human beings; or a shelter that provides temporary living arrangements (e.g., congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by government programs); or who is exiting an institution and was homeless before entering that institution;
2. An individual or family who will lose their primary nighttime residence within 14 days; who has not found a new residence; and who lacks the resources or support networks to obtain other permanent housing;
3. An unaccompanied youth under 25 years of age, or families with children and youth, who are defined as homeless under another federal statute; have not had permanent housing in the past 60 days; have experienced persistent instability (e.g., two or more moves in the past 60 days); and are expected to remain unstably housed because of disabilities, health conditions, substance addiction, histories of domestic violence, or multiple barriers to employment; or

4. Any individual or family who is fleeing domestic violence or other dangerous or life-threatening conditions related to violence; who has no other residence; and who lacks the resources or support networks to obtain other permanent housing.

Category 1 of HUD's definition includes most of McKinney-Vento's original definition of homelessness, which is now thought of as literal homelessness. Category 2 includes people who are facing eviction, or those who are staying with friends or family, termed *doubling up*, and have been told that they must move within 14 days. Category 3 includes youth or families who are doubling up, if they meet the additional conditions related to housing instability.

DOED uses a definition of homeless children and youths found in Section 725 of Subtitle VII-B of McKinney-Vento, and most recently amended by the Every Student Succeeds Act (ESSA; 2015). This definition of homeless children and youths includes four categories of individuals who "lack a fixed, regular, and adequate nighttime residence" (42 U.S.C. 11434a, 2016, p. 7175):

1. Children who are sharing others' housing due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate housing; are living in emergency shelters or transitional housing; or are abandoned in hospitals;
2. Children who have a primary nighttime residence that is a public or private place not intended as a sleeping accommodation for human beings;
3. Children who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and
4. Children who are migratory, and are living in one of the circumstances described above.

Unlike HUD's definition of homelessness, DOED's definition includes all children and youth who are doubling up. Also considered homeless are children living in motels and hotels because they have no other options; HUD considers people who are living in hotels and motels to be homeless only if a governmental program or charitable organization pays for the room (ESSA, 2015; HEARTH Act, 2009). The DOED definition is also used by the Department of Health and Human Services (DHHS) for the Head Start Act (1981).

### **Counting Homeless Families and Children**

Each year, HUD and DOED conduct counts of homeless people. However, neither department counts all of the people who are homeless according to their respective definitions. Due to the inconsistencies between HUD's and DOED's definitions and the difficulties of counting certain categories of homeless people, many people in homeless families remain uncounted.

**Estimates of homeless families.** HUD estimates homelessness using Point-in-Time (PIT) counts conducted on one night in January of each year (Henry et al., 2016). The 2016 PIT count estimated that 549,928 people were homeless. Of those, 194,716 people (35%) were part of 61,265 families that included children; 120,819 (22%) were children under the age of 18.

PIT counts provide data on two types of homelessness: *unsheltered* and *sheltered* (Henry et al., 2016). Unsheltered homelessness refers to people who are sleeping outside or in places not fit for human habitation, such as cars, barns, or abandoned buildings. Sheltered homelessness describes people who are sleeping in either emergency shelters or transitional housing. A decade ago, almost a quarter of homeless families were unsheltered; the 2016 PIT counts found that 90% of people in homeless families and 92% of children under 18 were sheltered (Henry et al., 2016).

HUD uses PIT counts and reports from the communities conducting the counts to develop yearly estimates of sheltered homelessness (Solari et al., 2016). HUD estimated that a total of 481,410 people in families with children used an emergency shelter or a transitional housing program at some point in 2016; 60.8% (292,697) of them were children under the age of 18 (Solari et al., 2016). Approximately half (49.6%, or 145,178) of sheltered homeless children were under six years old; 10.7% (31,318) were infants less than one year old (Solari et al., 2016).

According to HUD, the average size of a homeless family in the United States is three people, typically a single mother in her 20s with two children (Solari et al., 2016). In 2016, 77.6% of the adults in sheltered homeless families with children were women (Solari et al., 2016). This percentage is lower than it has been in previous years, and may reflect an increase in shelters that accept adult men and adolescent boys along with their families, or an increase in the number of families led by two parents or a single father that are becoming homeless.

Homeless families are predominantly racial and ethnic minorities (Henry et al., 2016). In 2016, 49% of people in families who were sheltered were Black, 37% were White, 2% were Native American, 1% were Asian, 2% were Pacific Islander, and 10% included multiple races. Thirty-two percent of people in sheltered families were Hispanic/Latino, and 68% were non-Hispanic. This proportion of Black and Hispanic people in homeless families is notably much higher than their proportion in the United States population overall (13.3% and 17.8%, respectively; U.S. Census Bureau, n.d.), or among those categorized as living in poverty (22% and 20% respectively; Henry J. Kaiser Family Foundation, n.d.).

**Counts of homeless children and youth.** DOED conducts a yearly count of homeless children and youth enrolled in public schools, using data collected from state education agencies (National Center for Homeless Education [NCHE], 2017). In school year 2015–2016, DOED

counted 1,304,803 homeless children and adolescents enrolled in grades K–12 and preschool. The vast majority (985,932 or 75%) of these children and adolescents were living in doubled-up situations; 186,868 were living in emergency shelters or transitional housing; 43,194 were unsheltered; and 84,963 were living in hotels or motels.

The U.S. Department of Health and Human Services (DHHS) counts the number of homeless children who participated in Head Start or Early Head Start programs. McKinney-Vento requires that Head Start programs recruit and give admission preference to homeless children. In 2016, 52,764 homeless children were enrolled in Head Start programs; this represented 5% of Head Start enrollment (Office of Head Start – Services Snapshot, 2017).

**Gaps in counts of homeless families and children.** Many people whom HUD defines as homeless are not included in PIT counts. As noted, only people who are sleeping outside or in places not fit for human habitation or those living in emergency shelters and transitional housing are counted (Henry et al., 2016). People who are in other categories of homelessness are not included in PIT counts. Further, HUD does not generate yearly estimates of unsheltered homelessness.

DOED's count of homeless children and adolescents in grades K–12 and public preschools reveals important gaps in counts of young children and their parents. The DOED reports only children and adolescents enrolled in school; their parents and their siblings below school age are not counted. The 2015–2016 DOED count included over one million children and adolescents living in doubled-up situations or in hotels or motels (NCHE, 2017). If, as with sheltered homeless children, almost half of all homeless children in families are under the age of six, then one million young children who are homeless were not counted. Using DOED's definition of homeless children and youths, a recent estimate placed the number of homeless



children in the United States at nearly 2.5 million; this represents one in every 30 children in the country (Bassuk et al., 2014).

### **Factors Contributing to Family Homelessness**

Family homelessness is the result of interactions among a primary structural problem and individual factors that lead to housing insecurity, and precipitating events that render families unable to stay in their housing. The structural problem is the dearth of housing units that low-income families can afford (Buckner, 2014). Individual factors determine which of those low-income families are most likely to become homeless.

The United States has an alarming shortage of housing that low-income families can afford. Housing is considered affordable when it costs no more than 30% of a family's income; families who spend more than 30% on rent and utilities may have difficulty paying for other necessities such as food, clothing, health care, and transportation (HUD, 2017; National Low Income Housing Coalition [NLIHC], 2017a). In 2016, an adult working 40 hours per week at the local minimum wage could not rent a safe, decent one-bedroom apartment in any state in the country without paying more than 30% of her or his income (NLIHC, 2017a). On average, an adult would have to work 94.5 hours per week at minimum wage to afford a one-bedroom apartment. In 2016, only three million rental units were affordable for 11.4 million extremely low-income (ELI) renter households (i.e., households with incomes below the poverty line or less than 30% of median income for their area) (NLIHC, 2017b). Over 70% of ELI households spent more than half of their very limited incomes on housing; the vast majority of all low-income households (i.e., households making up to 80% of area median income) paid more than 30% of their incomes for housing.

Buckner (2014) conceptualized individual factors related to family homelessness as *vulnerability factors* and *protective factors*. Vulnerability factors for homelessness “share in common a propensity to make it harder to have a well-paying job (hence income or savings) and/or strain the willingness of one’s social networks to provide housing support over an extended period” (p. 11). Protective factors decrease the likelihood that a family will become homeless.

Vulnerability factors for homelessness include demographic factors identified in counts of homelessness: being a young, single, Black or Hispanic mother with young children (Henry et al., 2016). Additional vulnerability factors include having a limited education, limited income or savings, and little or no work history; having limited social networks and family supports; experiencing intimate partner violence (IPV), childhood abuse or assault, or other violent victimization; and experiencing mental health and/or substance use problems. Single mothers who are responsible for young children may have difficulties finding and keeping full-time jobs (Buckner, 2014). While more than 75% of adults in the United States have graduated from high school or have a GED, fewer than 65% of homeless mothers have a high school education (Brumley et al., 2015; Perlman & Fantuzzo, 2013). This lack of education limits their ability to find well-paying jobs; the average income of homeless mothers is significantly below the federal poverty line (Buckner, 2014). Further, for mothers who are working, paying for childcare reduces their net incomes. Most homeless mothers have had some work experience, but the vast majority are not holding jobs when they become homeless (Buckner, 2014). The majority of homeless mothers have experienced IPV, sexual abuse, or other violent victimization. As many as 96% of homeless mother report experiences of violent victimization (Easterbrooks &

Graham, 1999); over 40% of homeless mothers have experienced sexual abuse (Weinreb, Buckner, Williams & Nicholson, 2006).

Protective factors include major governmental assistance programs that provide income or reduce costs for low-income families (Buckner, 2014). Housing assistance programs limit families' rent payments to no more than 30% of their incomes; examples of such programs are public housing owned by municipal agencies, and permanent subsidies (e.g., Section 8 vouchers) for market-rate housing. Entitlement programs help families to cover basic needs; these include Temporary Assistance for Needy Families (TANF or cash assistance), the Supplemental Nutrition Assistance Program (SNAP or food stamps), and Medicaid, which provides health care for low-income families.

For families who have many vulnerability factors and limited protective factors, and whose housing is unaffordable, a single event may lead to homelessness. Some events reduce family income (e.g., the loss of a job, or the loss of a partner's income due to divorce or separation), while others add expenses to an already strained budget (e.g., a raise in rent, or unexpected medical expenses due to illness or injury). Some families become homeless when fleeing intimate partner violence.

### **Housing Options for Homeless Families**

Homeless families are considered sheltered if they live in either *emergency shelters* or *transitional housing* (Henry et al., 2016). An emergency shelter is “any facility, the primary purpose of which is to provide a temporary shelter for the homeless in general or for specific populations of the homeless, and which does not require occupants to sign leases or occupancy agreements” (HUD Definitions, 2012, p. 516). Transitional housing is “a project that is designed to provide housing and appropriate supportive services to homeless persons to facilitate

movement to independent living within 24 months, or a longer period approved by HUD” (HUD Definitions, 2012, p. 519).

In 2016, a total of 209,122 emergency shelter and transitional housing beds were available for homeless families with children (Henry et al., 2016). The number of beds exceeds the number of people in families with children who are homeless on a given night. However, mismatches between the locations of and entry requirements for the available beds and the people who need them may result in waiting lists at shelters in some locations, and empty beds in others. Emergency shelter or transitional housing may be available in a city far from a family that becomes homeless, or the family may not meet the entry requirements (e.g., sobriety, number and ages of children, willingness to participate in services) for a shelter or transitional housing program that has space available.

The HEARTH Act signaled a shift in federal policy by, “establish[ing] a Federal goal of ensuring that individuals and families who become homeless return to permanent housing within 30 days” (HEARTH Act, 42 U.S.C. 11301, 1002(b)(3), 2009). This prioritization of permanent housing has changed the distribution of shelter options for homeless families. The number of emergency shelter beds has increased, and the number of transitional housing beds has decreased (Henry et al., 2016). Federal funding that had been allocated to transitional housing programs has been redirected to programs focused on permanent housing: *rapid rehousing* and *permanent supportive housing*. This section includes a discussion of emergency shelters and transitional housing, followed by basic information on rapid rehousing and permanent supportive housing.

**Emergency shelters.** In 2016, emergency shelters provided 133,523 beds for homeless families with children (Henry et al., 2016). Sleeping accommodations vary by shelter. Some shelters provide a bedroom for each family but have shared bathrooms and common spaces,

while others have congregate bunkrooms that are shared by two or more families (cite). Some shelters occupy former motels, so each family has a room with a private bathroom (Gonzalez, 2016). One Seattle-area shelter houses many families in large rooms, with family-sized camping tents providing some visual privacy (M. Hartman, personal communication, October 23, 2015).

Despite the Federal government's goal of quickly moving homeless families to permanent housing, families' median length of stay in emergency shelter increased between 2007 and 2016 from 30 nights to 49 nights (HUD, 2017; Solari et al., 2016). While 39% of people in families stayed in emergency shelters for less than a month, 44% were in shelters from one to six months, and 17% from six months to a year.

HUD's funding for emergency shelters covers supportive services that may include case management, childcare, education services, employment assistance and job training, outpatient health services, legal services, life skills training, mental health services, substance abuse treatment services, and transportation (HUD, 2018). The supportive services available to families in emergency shelters vary by shelter. All shelters provide case management to help families find long-term housing and enroll in entitlement programs.

When families with children move into emergency shelters, both parents and children face a wide range of stressors. In a qualitative study on the effects of living in a shelter on mothers and their children under six years old, mothers reported feeling disempowered by the rules of the shelter (Anthony, Vincent, & Shin, 2018). Mothers were required to keep their children with them at all times, limiting the children's ability to explore and play on their own and the mothers' ability to have time alone. Mothers felt that their parenting was constantly monitored by shelter staff; some described staff threatening to report them to Child Protective Services (CPS). Daily schedules that were formerly the mother's responsibility were set for the

entire shelter and enforced by shelter staff. Wake-up and lights-out times were set for the shelter, and were different from the family's usual patterns. Shelter staff determined meal times, and the foods offered differed from the family's usual diet. Shelter residents had to wait for shared bathrooms and laundry facilities. Some shelters required that families leave the shelter during the day (i.e., 8:00 am to 5:00 pm), with children either attending school or in daycare, and parents working, looking for work or housing, or attending a job training program (Gonzalez, 2016).

**Transitional housing.** In 2016, transitional housing programs provided housing for 75,599 people in homeless families with children (Henry et al., 2016). Transitional housing may be project-based, with all residential units or family bedrooms in a single building or cluster of buildings, or scattered-site, with residential units managed by one program in a variety of locations. Federal regulations limit residency in transitional housing to a maximum of two years; some programs have time limits of six months to a year (Burt, 2006; Holtrop, McNeill, & McWey, 2015). Transitional housing programs must provide supportive services to help homeless families transition to permanent housing and must continue to offer services for at least six months after families exit the transitional housing.

During the past decade, families' median length of stay in transitional housing decreased from 151 nights in 2007 to 140 nights in 2016 (HUD, 2017; Solari et al., 2016). These figures denote occupancy during a single year only, rather than describing families' total length of stay in transitional housing. Gubits et al. (2016) found that families typically lived in transitional housing between 11 and 15 months.

The supportive services available to families in transitional housing vary by housing program (Burt, 2006). Services may be provided on-site by program staff or staff from other agencies, or off-site at agency offices. Burt (2006) found that almost all programs had on-site

case management and budgeting/money management classes. Most programs provided on-site services related to basic needs (e.g., food, clothing), tenant stabilization, daily living skills, conflict resolution, accessing permanent housing and entitlements, and job placement. About 80% of programs provided mental health services either on-site or off-site, although most mental health services focused on adults.

Living in transitional housing presented a range of stressors for mothers and children that were similar to those found in shelters. Mothers felt that they were “parenting in a fishbowl,” with their parenting monitored by shelter staff and other parents (Holtrop et al., 2015, p. 185). Daily schedules that were formerly the mother’s responsibility may be set for the entire shelter and enforced by shelter staff. Wake-up and lights-out times may be different from the family’s usual patterns. Shelter staff may determine meal times, and the foods offered may differ from the family’s usual diet. Waits for shared bathrooms were difficult for children, particularly when younger children were toilet training (Holtrop et al., 2015).

**Rapid rehousing.** Rapid rehousing programs provide time-limited assistance to help families obtain permanent housing quickly (HUD, 2014). In 2016, rapid rehousing programs provided housing for 56,589 people in families with children (Henry et al., 2016). Families who are rehoused through rapid rehousing programs are no longer homeless according to HUD’s definition. Rapid rehousing has three core components: housing identification, rent and move-in assistance, and case management (HUD, 2014). Program staff help families to find safe, decent rental housing that will be affordable when rental assistance ends, and address landlord concerns about prospective tenants. The program covers move-in costs and security deposits and pays rent and utilities until the family has sufficient financial resources to assume payments. Case

management focuses on helping families find appropriate housing, resolve immediate crises that contributed to their homelessness, and connect to services in the community as needed.

**Permanent supportive housing.** Permanent supportive housing programs provide long-term housing for families who have been chronically homeless or in which the head of household has a disability (Henry et al., 2016). In 2016, permanent supportive housing programs provided housing for 122,978 people in families with children. Families living in permanent supportive housing are also no longer homeless according to HUD's definition. Bassuk, Huntington, Amey, and Lampereur (2006) found that supportive services varied by program; all programs had case management and most provided services related to basic needs (e.g., food, clothing), money management, conflict resolution, and accessing entitlements. Some programs provided substance use and mental health services, although primarily for adult residents.

## **Summary**

Family homelessness has increased since the early 1980s, and shows no sign of remitting. Families who become homeless have experienced a wide variety of hardships, stressors, and traumas by the time they lose their housing. Becoming homeless creates additional stresses and traumas for mothers and children who may already be vulnerable to mental health problems. Goodman, Saxe, and Harvey (1991) asserted that homelessness was a risk factor for trauma-related and other emotional disorders. First, becoming homeless might in itself be psychologically traumatizing. The loss of one's home, as well as neighbors, social roles, and day-to-day schedules, might produce psychological symptoms. Second, the ongoing experience of being homeless – living in a shelter or on the street, with the attendant losses of control and possibly safety – might undermine coping mechanisms and lead to mental health problems. Finally, homelessness might exacerbate traumatic responses in people who had histories of



violent victimization, which are common among mothers who become homeless. Chapter III is a review of the literature on the associations among homelessness, maternal mental health, and children's mental health.

## CHAPTER III

### Family Homelessness and Mental Health

Family homelessness results from an insufficient supply of affordable housing paired with the accumulation of financial hardships, vulnerabilities, stressors, and traumas that eventually overwhelms a family's capacity to maintain housing. Becoming homeless and navigating homeless service systems involve further stressors and traumas for mothers and their children that may render them particularly vulnerable to mental health problems. This chapter begins with a brief discussion of mental health assessment in research and clinical practice, and then reviews the literature on the relationships between maternal mental health and children's wellbeing, between family homelessness and maternal mental health, and between family homelessness and children's mental health.

#### Mental Health Assessment

In clinical practice and in studies of mental health, therapists and researchers use a variety of instruments to screen for or to diagnose mental health disorders. Some instruments screen for particular disorders, such as major depressive disorder (MDD), post-traumatic stress disorder (PTSD), and generalized anxiety disorder (GAD). Others, particularly those used for children (e.g., the Child Behavior Checklist [CBCL]), also consider categories of behavior; the categories of *internalizing* and *externalizing* behaviors are two of the most common.

*Internalizing* problems are turned inward toward the self, and are the result of *overcontrol*, or maladaptive attempts to regulate emotions and impulses (Merrell, 2008). Internalizing behaviors

include depression, anxiety, withdrawal, and somatic complaints (i.e., physical symptoms that are psychological in origin). *Externalizing* problems are directed outward toward others, and result from *undercontrol*, or poor regulation of emotions and impulses. Externalizing behaviors include aggression and destructiveness; some instruments also include attention problems in young children as externalizing. Both internalizing and externalizing problems indicate a lack of adaptive self-regulation. Some people experience both internalizing and externalizing problems; a child who is depressed or anxious may also be disruptive, get into fights, have difficulty paying attention, or destroy possessions or property. One of the most commonly used assessment instruments for children is the Child Behavior Checklist (CBCL), a set of caregiver-report and teacher-report forms for children in different age groups (e.g., 1 1/2–5 years, 6–17 years). The CBCL includes subscales for both internalizing and externalizing problems; scores may be reported for total problems, for the internalizing or externalizing subscales, or for particular components of internalizing or externalizing problems (e.g., depression as a component of internalizing, or aggression as a component of externalizing).

### **Maternal Mental Health and Children’s Wellbeing**

While vitally important, the multifaceted relationship between maternal depression and children’s wellbeing is beyond the focus of this thesis. However, some basic information about maternal depression and its relationship to children’s wellbeing helps to provide context for the discussion about family homelessness. Depression is a major mental health problem for mothers and their children. Approximately 10% of all caregiving mothers (i.e., mothers with children in their care) in the United States experience a major depressive disorder (MDD) in a given year; approximately the same percentage of children experience living with a depressed mother (Ertel et al., 2011). Maternal depression has been linked to risks to children’s wellbeing in multiple

domains, including physical health, cognitive development and academic performance, and emotional and behavioral outcomes (Turney, 2011).

**Depression in caregiving mothers.** Depression in caregiving mothers is associated with multiple demographic characteristics. In a sample of caregiving mothers ( $n = 8,916$ ) drawn from the National Epidemiological Survey of Alcohol and Related Conditions, a nationally representative survey of the civilian U.S. population in 2001-2002, Ertel et al. (2011) found a significantly higher prevalence of depression in low-income mothers than in those with higher incomes, in unemployed mothers than in those who were employed, in younger mothers than in older mothers, in mothers with less than a high school education than in those with more education, and in unmarried mothers than in married mothers ( $p < .01$  in all analyses). Mothers who reported depression had experienced significantly greater adversity ( $p < .01$ ) on average than those who did not report depression. The survey from which Ertel et al. took their sample measured depression using the Alcohol Use Disorder and Associated Disabilities Interview Schedule-IV (AUDADIS-IV).

Ertel et al.'s (2011) study considered the following adversities: experiencing a job loss, a separation or divorce, or a financial crisis (e.g., declaring bankruptcy or being unable to pay bills), or living below 150% of the federal poverty line. Over three-quarters of depressed mothers had experienced one or more of these adversities in the previous year; the majority of non-depressed mothers had experienced none of them. While Black and Hispanic mothers had significantly lower rates of depression than White mothers ( $p < .01$ ), those who were depressed had significantly higher rates of unemployment ( $p = .02$ ), financial crisis ( $p = .02$ ), and poverty ( $p < .01$ ) than their White counterparts. Approximately half of depressed mothers received

mental health treatment for their depression, but significantly fewer Black and Hispanic mothers received treatment than White mothers ( $p < .01$ ).

A robust literature links maternal depression with adverse emotional and behavioral outcomes in children. In a meta-analysis of 193 studies published prior to 2009 on the association between maternal depression and children's behavioral and emotional problems, Goodman et al. (2011) found significant positive relationships ( $p < .001$ ) between maternal depression and higher levels of children's internalizing problems, externalizing problems, and overall psychopathology. However, because "most studies sampled largely homogeneous, middle- and upper-middle-income, predominantly Caucasian families" (p. 17), the researchers' abilities to examine the effects of contextual differences such as race/ethnicity, socioeconomic status (SES), mothers' marital status, and maternal age were limited. Not surprisingly, these contextual factors were interrelated: Goodman et al. (2011) found that samples with higher percentages of racial/ethnic minority families had higher percentages of unmarried mothers and low-SES families than the overall meta-analysis sample.

Analyzing only the group of studies that included or focused on understudied populations, Goodman et al. (2011) found stronger positive associations between maternal depression and children's behavioral and emotional problems than in the full meta-analysis sample. Studies of low-SES families yielded stronger associations between maternal depression and children's mental health problems than studies with middle-class samples. Studies with more unmarried mothers showed stronger positive associations between maternal depression and children's externalizing problems than those with more married mothers. Studies that had higher percentages of racial/ethnic minority mothers showed stronger associations between maternal depression and children's internalizing and externalizing problems than those with more White

mothers. Children from low-income, racial/ethnic minority families with depressed single mothers had more emotional and behavioral problems than White, middle-class children with depressed married mothers.

As noted, most of the studies in Goodman et al.'s (2011) meta-analysis were conducted with samples consisting mainly of White, middle-to-upper class, two-parent families. Overwhelmingly, homeless families are impoverished and are predominantly racial and ethnic minorities; the vast majority of homeless mothers are single (HUD, 2016b). Goodman et al.'s findings suggest that many studies that have linked maternal depression and children's mental health problems may not be generalizable to the families with young children who are at greatest risk for homelessness, and that more research is needed to understand possible mediating or moderating factors in the relationship between maternal depression and children's mental health. Research using samples with demographic characteristics similar to those of homeless, unstably housed, and other low-income families might generate findings that better represent the experiences of these families. One such sample is the Fragile Families and Child Wellbeing Study, briefly described below, which provided data analyzed in several studies reviewed for this thesis (Curtis, Corman, Noonan, & Reichman, 2014; Park, Fertig, & Allison, 2011; Park, Fertig, & Metraux, 2011; Suglia, Duarte, & Sandel, 2011; Turney, 2011).

**Fragile Families and Child Wellbeing Study.** The Fragile Families and Child Wellbeing Study (FFCW) was a longitudinal study that followed the families of 4,789 children born between 1998 and 2000 in 20 large U.S. cities (Reichman, Teitler, Garfinkel, & McLanahan, 2001). Because the researchers were interested in the experiences of families with unmarried parents, the study included children born to 3,648 unmarried couples and 1,141 married couples. The sample was racially and ethnically diverse (21% White non-Hispanic, 48%

Black non-Hispanic, 27% Hispanic, 4% other) (Bendheim-Thoman Center for Research on Child Well-being [BTC], 2008a).

Researchers interviewed the mothers following their children's births, and again when the children were one, three, five, and nine years old. Response rates for the follow-up waves were 89% ( $n = 4,270$ ) at one year, 86% ( $n = 4,140$ ) at three years, 85% ( $n = 4,055$ ) at five years, and 76% ( $n = 3,515$ ) at nine years (BTC, 2008a; BTC, 2011). When the children were three years of age, the study included an optional in-home interview, which 62% ( $n = 2,268$ ) of mothers completed. At their children's births, 36.1% of the mothers were living in poverty (i.e., had incomes  $< 100\%$  of the federal poverty level). The percentages of families living in poverty at each wave were 27.0% at one year, 43.7% at three years, 29.8% at five years, and 37.3% at nine years (BTC, 2008b; BTC, 2011).

Interviews at each wave of the FFCW included questions about housing status and the number of moves during the previous year, and screened for mothers' and children's mental health (BTC, 2008a). Maternal depression and anxiety were measured using the Composite International Diagnostic Interview-Short Form (CIDI-SF). Maternal parenting stress was assessed using items adapted from the Parenting Stress Index and the Child Development Supplement of the Panel Study of Income Dynamics. Children's psychological problems were assessed using the Child Behavior Checklist (CBCL). Attachment was assessed during the three-year in-home interview using the Toddler Attachment Q-Sort (TAQ).

The strengths and limitations of the FFCW data generalize across the studies that have used these data. The large sample size lends credibility to findings. Because families were recruited from 20 large cities, the findings may not generalize to families living in smaller municipalities and rural areas. However, the number of cities from which the sample was drawn

makes it more representative of and generalizable to an urban population than a sample drawn from a single city. Because the vast majority of the children were born to single mothers, findings may not generalize to families with married parents. The questions about housing status asked whether the family a) had slept in a shelter or a place not intended for human habitation, or b) had stayed with family or friends (i.e., had doubled up) because they had no housing. The first question generated data that are useful only for studying the incidence of literal homelessness, and not its duration or category (e.g., sheltered or unsheltered). Researchers who used FFCW data were constrained by the questions that the original investigators included; they might have operationalized variables of interest (e.g., housing instability) differently had they been collecting data.

**Chronic and proximate depression.** Turney (2011) found that chronic or recurrent maternal depression was a greater risk to children's mental health than a single episode of depression. Using data from three waves (i.e., years one, three, and five) of the FFCW ( $n=2,427$ ), Turney found that mean CBCL internalizing and externalizing scores were significantly higher ( $p < .05$ ) in children whose mothers had reported depression in two or three waves than in those whose mothers reported depression in only one wave; children whose mothers had never reported depression had the lowest mean CBCL scores. Additionally, Turney found that maternal depression reported during year five was associated with greater child behavior problems, on average, during year five than maternal depression reported during years one or three: Children experienced greater problems while their mothers were experiencing depression.

### **Homelessness and Maternal Mental Health**

Since the literature suggests that maternal mental health problems, particularly depression, are associated with increased mental health problems in children, understanding



whether family homelessness is associated with increased maternal mental health problems is crucial. The rapid increase in family homelessness in the 1980s led to research on mothers experiencing homelessness with their children; with family homelessness a persistent problem, this research has continued. Among the mental health disorders that researchers have studied in homeless mothers with children in their care are major depressive disorder (MDD), generalized anxiety disorder (GAD), and post-traumatic stress disorder (PTSD); in this section, all three are discussed.

Caregiving mothers who are homeless have many of the characteristics that Ertel et al. (2011) found to be associated with maternal depression. The majority of these mothers are young, have little education, and are single parents. They are also living in poverty and may have become homeless after losing a job, separating from a partner, or having financial problems. Rates of maternal MDD are higher for mothers who have experienced homelessness or doubling up than for housed low-income mothers (Park, Fertig, & Metraux, 2011). In a comparison of mothers who were homeless in 1993 and 2003, Weinreb, Buckner, Williams, and Nicholson (2006) found that 45% of mothers who were homeless in 1993 and 85% of mothers who were homeless in 2003 reported a lifetime incidence of major depressive episodes.

Mothers who had experienced homelessness or doubling up in the past year reported a significantly higher prevalence of MDD ( $p < .05$ ) than their low-income housed counterparts; homeless mothers also had significantly higher rates of GAD ( $p < .05$ ) than their housed counterparts. (Park, Fertig, & Metraux, 2011). Using data from three waves (i.e., years one, three, and five) of the FFCW, Park, Fertig, and Metraux (2011) studied 2,631 families who either had incomes below the federal poverty level or reported homelessness or doubling up in the previous year during at least one survey wave. Almost ten percent (9.8%) of this sample had

been homeless, and an additional 23.6% had one or more episodes of doubling up. The researchers found that 35% of homeless mothers had MDD at one year, 37% at three years, and 33% at five years. Homeless mothers had twice the odds of MDD as those who had not been homeless; doubling up was associated with a 50% increase in the odds of MDD.

Zabkiewicz et al. (2014) found that caregiving mothers who were homeless had, on average, higher rates of mental health disorders than other homeless women; mental health disorders were associated with the duration of homelessness in caregiving mothers. Using a sample of homeless women ( $n = 713$ ), approximately half White and half non-White, from five large Canadian cities, these researchers studied the association between caregiving status (i.e., whether the woman had children in her care) and mental health, particularly whether the length of homelessness affected that relationship. The sample women completed the MINI-International Neuropsychiatric Interview. Sixty-six percent of caregiving mothers screened positive for MDD and 49.8% for PTSD; these percentages were significantly higher than in women not caring for children (52.9% and 35.8% respectively,  $p < .01$  in both analyses). The researchers found no association between caregiving status and mental health symptoms among women who had been homeless for fewer than two years. After having been homeless for two or more years, caregiving mothers were twice as likely as those who were not caregiving to meet criteria for MDD, and almost twice as likely to meet criteria for PTSD. Because of its cross-sectional design, this study could not establish a causal relationship between mothering status and mental health disorders. However, the findings suggested a possible relationship between long-term homelessness and poor mental health outcomes for caregiving mothers. Because this study was conducted with homeless women in Canada, findings may not be generalizable to homeless women in the United States, where long-term family homelessness is rare.

While homelessness may be a risk factor for maternal depression, Curtis et al. (2014) posited a bi-directional association between homelessness and poor mental health; maternal depression may also be a risk factor for subsequent family homelessness. Using a sample ( $n = 2,974$ ) from years one and three of the FFCW, Curtis et al. (2014) explored whether maternal MDD during the first year of children's lives might significantly increase the odds of subsequent family homelessness. Compared to non-depressed mothers, mothers who had experienced MDD during the postpartum year were more than twice as likely (odds ratio=2.29) to become homeless and almost one-and-a-half times as likely (odds ratio=1.40) to be at risk for homelessness within the next two years. The researchers operationalized risk for homelessness as having experienced an eviction, having moved more than three times between years one and three, or having been doubled up with family or friends. Odds ratios do not imply causality; instead, they describe the strength of the association between two variables. An unidentified confounding variable might have mediated the association between postpartum depression and housing status.

Homelessness is not the only housing problem associated with maternal mental health problems. Using the sample of mothers in the FFCW who participated in the year three in-home interview, ( $n = 2,104$ ), Suglia et al. (2011) examined the associations between housing factors (e.g., housing quality, housing instability) and MDD or GAD. In the in-home interview, FFCW investigators rated indoor housing quality, including housing disarray (e.g., dark, dirty, cluttered, crowded, and noisy) and housing deterioration (e.g., peeling paint and holes in the floor). Mothers' reports that they had moved more than twice in the previous two years were used as an indicator of housing instability. Suglia et al. found that housing instability and housing disarray were associated with maternal depression and anxiety. Specifically, 16% of women screened positive for MDD and 5% screened positive for GAD. Adjusting for other factors, including

demographic characteristics, financial hardships and intimate partner violence (IPV), mothers who experienced housing instability or housing disarray were significantly more likely to report depression (odds ratio = 1.77 for instability, 1.33 for disarray). In particular, mothers whose housing disarray involved factors beyond their control (e.g., crowded, noisy) were more likely to report depression. On average, mothers who experienced housing instability were significantly more likely to screen positive for GAD than mothers who had not experienced such instability. Suglia et al. also found that both financial hardships and IPV, common among unstable housed mothers, were significantly associated with MDD and GAD.

### **Homelessness and Children's Mental Health**

Given that maternal depression is associated with children's mental health problems, and that homelessness and housing instability are associated with maternal depression, one would hypothesize that homelessness would also be associated with children's mental health problems. In this section, several studies that link homelessness and children's mental health issues are presented. Early research on children in homeless families showed relationships between homelessness and mental health problems (Bassuk and Rubin, 1987; Buckner, 1987). However, the earliest studies compared the mental health assessments of homeless children only to norms from the general population, rather than to assessments of housed children of similar SES (Buckner, 2008). When researchers also considered control groups of housed low-income children, they sometimes found few differences between homeless children and housed low-income children; they also found significantly higher rates of mental health problems in both these groups than in the general population. Some more recent studies of homeless children have considered possible contributions of the mother-child relationship to children's functioning (Harpaz-Rotem et al., 2009; Herbers, Cutuli, Monn, Narayan, & Masten, 2014). Some

researchers have suggested that young children's responses to homelessness and other associated traumas and stresses may be mediated by attachment to their mothers or primary caregivers (Bassuk et al., 2015).

Young children who have been homeless have significantly more mental health problems at five years of age than housed low-income children. Using the same sample of families ( $n = 2,631$ ) from the FFCW as Park, Fertig, and Metraux (2011), Park, Fertig, and Allison (2011) found that children who had experienced homelessness or doubling up had a higher occurrence of emotional and behavioral problems, on average, than housed low-income children. Specifically, five-year-old children who had been homeless had significantly higher mean total and internalizing CBCL scores than housed low-income children ( $p < .05$ ). Researchers also found that, independent of housing status, lower maternal education, which is a vulnerability factor for homelessness and is associated with maternal depression, was significantly associated with greater mental health problems and poorer cognitive development in children.

Poor housing quality and housing instability are also associated with poorer emotional and behavioral functioning in children, although the associations are partially mediated by maternal mental health and parenting stress. Coley, Leventhal, Lynch, and Kull (2012) used data from three waves (e.g., 1999, 2001, 2005) of the Three-City Study, a longitudinal study of racially diverse children ( $n = 2,437$ ; 40% Black, 62% Hispanic, 6% White) from low-income urban neighborhoods in Boston, Chicago, and San Antonio. They assessed housing quality and maintenance problems (e.g., leaking roofs, broken windows, rodents, heater not working, peeling paint or exposed wiring), residential stability (i.e., number of moves reported in the year prior to each of the three study waves), housing type (e.g., ownership status, subsidy status), and housing cost to determine associations with children's mental health and cognitive development. Coley et

al. also considered the possible mediating effects of maternal mental health, parenting stress, and family functioning. Children's psychological functioning was assessed using the CBCL; interviewers also assessed children's reading and math skills. Maternal psychological functioning was assessed using the Brief Symptom Inventory, a measure of mental health, and the Panel Study of Income Dynamics, a measure of parenting stress; family functioning was assessed using a measure of family strength-building routines (e.g., eating dinner together at the same time every day). Poor housing quality was significantly associated with greater internalizing and externalizing problems ( $p < .01$  for both associations). Additionally, decreases in housing quality over time (i.e., between study waves) were associated with increases in emotional and behavior problems. Children whose families moved more frequently, based on maternal reports of a move in the year prior to each study wave, had on average greater internalizing and externalizing problems than children who had fewer moves ( $p < .01$ ). The associations between housing quality and instability and children's mental health were mediated in part by maternal psychological distress, parenting stress, and family routines. Coley et al. (2012) posited these linkages between poor housing, maternal mental health, family processes, and children's functioning:

Low-quality housing may induce stress in parents, increase mental health problems, and limit their ability to regulate family activities, in turn affecting children's socioemotional functioning. Thus, rather than being a source of security and escape from life's pressures, a home with quality deficiencies may add to other stresses experienced by poor families, leading to a cumulative negative impact on well-being. (p. 1785)

A strength of Coley et al.'s (2012) study was its longitudinal design, which made it possible to explore the associations between housing deterioration and instability and children's mental health over time.

Increased depression and anxiety symptoms in homeless children may be related more to maternal mental health than to homelessness. Harpaz-Rotem et al. (2009) studied associations among children's mental health, family homelessness, and maternal PTSD and other mental health conditions. Using the Children's Problems Checklist for children, and the PTSD Checklist (PCL) and Symptoms Checklist-Revised (SCL-30) for mothers, they assessed 142 mothers (63% Black, 27% White, 6% Hispanic, 4% other) who were veterans of the U.S. armed forces at three-month intervals for one year. Their findings suggested that increased depression and anxiety symptoms among children were associated primarily with maternal PTSD, not depression. They found no associations between family homelessness or housing instability and children's mental health symptoms. Harpaz-Rotem et al. (2009) noted that, because their sample was limited to female veterans who were homeless or unstably housed, their findings might not be generalizable outside of the veteran community. An additional limitation is that the study did not include a control group of stably housed female veterans, who might also have had mental health problems related to their military service.

Despite the effects of stressful life events on their children's mental health, homeless mothers' capacities for positive co-regulation (PCR) with their young children serve as a buffer. Using a sample of children ( $n = 138$ ) living in emergency shelters with their families, Herbers et al. (2014) examined the associations among experiencing stressful life events, trauma symptoms, emotional and behavioral problems, and parental positive co-regulation; in measuring stressful life events, the researchers used a list of 20 potentially traumatic events. Two-thirds of families

were Black, 16% were multi-racial, and 6% each were White, Native American, and another race. The children were 4–6 years old. Herbers et al. administered cognitive and emotional assessments to each child, interviewed each parent (elaborate), and conducted structured interaction tasks in which parent and child participated together to assess for PCR. Herbers et al. found that over a quarter (28%) of children had CBCL scores indicating emotional and behavioral problems, compared to 18% in the general population for this age group.

Experiencing increasing numbers of adverse events was associated with higher mean scores on the CBCL. Positive co-regulation (PCR) was associated with lower mean CBCL scores; this association was stronger for children who had experienced greater adversity. For trauma symptoms and emotional/behavior problems, PCR likely played both a promotive role, helping all children, and a protective role, buffering the impact of stress for children who experienced higher levels of trauma and adversity.

A lack of controls and the limited assessment of mothers' psychological functioning are limitations in Herbers et al.'s (2014) study. Control groups of low-income housed children and more affluent children experiencing the stressful life events assessed in this study would provide data for evaluating whether Herbers et al.'s findings were related to homelessness. Assessing the mothers for mental health problems, particularly depression and PTSD, could have contributed to understanding the relationship between maternal mental health, PCR, and children's functioning.

**Continuum of Risk Hypothesis.** The Continuum of Risk Hypothesis is proposed to explain the differences found between homeless children and their low-income, housed counterparts is (Buckner, 2008). This theory describes three types of risk factors to which homeless children are exposed: risks specifically related to homelessness (e.g., stresses related to losing possessions or living in a shelter), risks shared with low-income children (e.g., hunger,



exposure to community violence), and risks that all children have in common (e.g., family dysfunction) regardless of family income. Homeless children, who are exposed to the greatest variety of risk factors, are located at the high end of the continuum of risk; low-income, housed children are in the middle, and children not living in poverty are at the low end. Researchers have hypothesized that homeless children, given their location at the high end of the risk continuum, are more likely than low-income, housed children or higher-income children to experience stressors that could lead to difficulties related to health, mental health, and academic functioning (Brumley, Fantuzzo, Perlman, & Zager, 2015; Buckner, 2008).

In an empirical test of the Continuum of Risk Hypothesis, Brumley et al. (2015) found that early homelessness in children was uniquely associated with social problems in first grade. Brumley et al. used a sample of low-income first-grade students in an urban school district ( $n = 4,594$ ), 481 of whom had a homeless shelter experience; 67% of the children in the full sample were Black, 17.3% were Hispanic, and 10.6% were non-Hispanic White. The researchers examined the relationships among early homelessness, risks associated with poverty and homelessness, and educational outcomes including classroom behavior. The co-occurring risks studied were birth risks (e.g., lack of prenatal care, low birth weight), lead toxicity, low maternal education, teen motherhood, and substantiated child maltreatment (e.g. neglect, physical abuse, or sexual abuse). Teachers completed a 14-item assessment instrument on academic and social engagement behavior in the classroom. The academic engagement scale included items such as “follows directions” and “asks for help when necessary;” the social engagement scale included items such as “works cooperatively with others” and “displays appropriate behavior in work and play” (Brumley et al., 2015, p. 33).

Brumley et al. (2015) found that children who had a homeless experience had, on average, a significantly higher prevalence of each of the five co-occurring risk factors than their housed low-income peers. These children's rate of maltreatment was three times that of their low-income peers ( $p < .001$ ). While homeless children had a higher rate of academic engagement problems than their housed peers, low maternal education and teen motherhood accounted for the difference. Children who had a homeless experience also had a higher rate of social engagement problems than their housed peers. After controlling for demographic factors and the predictive co-occurring risks (e.g., teen motherhood, low maternal education, history of maltreatment), the association between the homeless experience and social engagement problems remained significant ( $p < .001$ ). Brumley et al. posited that the experience of homelessness might create strains in the parent-child relationship (i.e., the attachment relationship) that would result in later difficulties in relationships with peers and teachers.

Limitations of Brumley et al.'s (2015) study relate to controls, the assessment method, and decisions regarding whom to count as homeless. The researchers did not examine low-income, housed children and the higher-income first graders in their cohort to determine whether significant differences existed between them, as the Continuum of Risk Hypothesis would suggest. Brumley et al. (2015) used a scale that has not been validated to measure academic and social engagement, so their findings may not be valid or replicable. By operationalizing homelessness as having stayed in a shelter, Brumley et al. did not capture the full range of homeless experience. DOED counts show that many more homeless students are doubled up than are in shelters, so some children that Brumley et al. included in their never-homeless group would almost certainly have experienced doubled-up homelessness.

While Brumley et al. (2015) identified one unique association between homelessness and children's mental health problems, some homeless children who are at risk for more types of adversity, per the Continuum of Risk Hypothesis, may experience few of those adversities, while housed, low-income children who are at risk for fewer types of adversity may experience adversities that prove more detrimental to their wellbeing. Buckner (2008) explained it in this way:

Put simply, in some studies it is hard to demarcate where the effects of poverty-related sources of risk end and homelessness-specific risks begin. That said, the problems that have been documented in homeless (and low-income housed) children are legitimate concerns, although it is often difficult to know to what extent these difficulties are attributable to housing status versus other factors. In some studies, homelessness may be a marker of risk for low-income children but not a major culprit in accounting for their current state of functioning. (p. 726)

Whether homelessness is a culprit or a marker of risk for children (and their mothers), any young homeless child who is living in an emergency shelter or transitional housing has been exposed to many stressors and/or traumas and is at risk for developing mental health problems.

### **Summary**

The literature discussed in this chapter outlines a set of complex interrelationships among a family's experience of homelessness or housing instability, maternal mental health, and various aspects of children's health. Maternal depression negatively affects children's mental health, physical health, and cognitive development. Young, single, ethnic/racial minority mothers with little education who are living in poverty have an elevated risk of depression (as well as an elevated risk for homelessness); becoming homeless or experiencing housing instability puts

them at higher risk for developing depression. Young children who experience homelessness or housing instability have higher rates of mental health problems than their low-income housed peers, although these differences appear to become more significant in school-aged children than in younger children.

Bassuk et al. (2015) suggested that, “the differences in the impact of homelessness may be explained by the fact that preschool children’s experience is largely mediated by their attachment to their mothers” (p. 94). Attachment theory suggests that increasing mental health problems when children start school and spend more time away from their mothers may be related to an insecure attachment. If children have not begun to develop the capacity for self-regulation that secure attachment affords before they start school, the lack of proximity to their mothers may lead to higher rates of mental health problems. Chapter IV focuses on attachment theory and research, and includes a discussion of the implications of attachment security for children’s mental health.

## CHAPTER IV

### Attachment Theory and Research

In the literature on relationships among mothers' and children's mental health, homelessness, and poverty discussed in Chapter III, some researchers (Bassuk, Richard, & Tsertsvadze, 2015; Brumley et al., 2017; Harpaz-Rotem et al., 2009; Herbers et al., 2014) have speculated that the associations between homelessness or poverty and children's mental health are mediated by the quality of children's attachments to their mothers. This chapter includes a discussion of the history and development of attachment theory, particularly the contributions of John Bowlby, Mary Ainsworth, and Mary Main; factors in the mother-child relationship that play a role in the child's development of a particular attachment style; instruments that have been developed to assess attachment in children and adults, the effects of trauma and contextual factors on attachment, and the associations between attachment security and children's mental health.

#### History of Attachment Theory

**John Bowlby.** Attachment theory originated with the work of John Bowlby, a British child psychiatrist and psychoanalyst. Bowlby first outlined his ideas about and evidence for attachment in his 1951 report for the World Health Organization, *Maternal Care and Mental Health*, which focused on children who had been orphaned and homeless during World War II (Bowlby, 1951). The report drew on empirical research from the 1940s by Bowlby and other psychoanalysts in England and America on the personality development and behavior of children

who had experienced maternal deprivation, usually but not always as the result of separation from their mothers. Bowlby (1951) wrote:

What is believed to be essential for mental health is that the infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother-substitute) in which both find satisfaction and enjoyment. Given this relationship, the emotions of anxiety and guilt, which in excess characterize mental ill health, will develop in a moderate and organized way. (p. 11)

Bowlby noted later that the report, which included empirical studies on the effects of maternal deprivation and recommendations for preventing it, did not include “any explanation of how experiences subsumed under the broad heading of maternal deprivation could have the effects on personality development of the kinds claimed” (Bowlby, 1988, p. 24). What Bowlby was lacking in 1951 was a theory.

Seeking to understand the behavior he had observed in children, Bowlby (1982) looked to ethology, the science of animal behavior, particularly studies of the bonds that the young of other species formed with their parents or parent substitutes. He referred to Harlow’s studies of young rhesus monkeys separated from their mothers (Harlow & Zimmerman, 1959), in which the monkeys were provided with a bare wire surrogate “mother” that provided milk from a bottle and a terrycloth-covered wire “mother” who had no milk. While the young monkeys would nurse from the wire mother, they much preferred the soft terry-covered mother. The warmth and comfort of the terry mother was more important than food to the young monkeys. Bowlby also referred to Lorenz’s work with goslings (Lorenz, 1935), in which Lorenz found that newly hatched goslings would imprint on or become attached to the first moving thing that they saw in their first hours of life. Bowlby noted that when Lorenz arranged for goslings to see him after

they hatched rather than their mother, the goslings imprinted on Lorenz, and would follow him around the laboratory. Since geese do not feed their offspring, imprinting was clearly related to something other than feeding; Bowlby theorized that it was related to protection.

Bowlby (1982) came to view attachment as a unique system with motivations independent of feeding or sex, which psychoanalysts at that time believed to be primary. Bowlby's thinking differed from that of psychoanalytic object relations theorists such as his former supervisor, Melanie Klein (1948), who saw the development of psychopathology as based primarily on unconscious fantasy, rather than being influenced by real life events. Bowlby (1982) believed that healthy development was based on real interactions between mother and child.

Bowlby's (1982) approach to developing attachment theory had a different orientation to time than previous psychological and psychoanalytic theory. Attachment theory was prospective, looking at early experience and projecting forward to later behavior, rather than retrospective, looking at adult behavior (particularly psychopathology) and working backwards to its causes in childhood. Rather than starting with material (feelings, thoughts, etc.) produced by patients in treatment during free association or play, and trying to build a theory of personality development, Bowlby started with observations of children's behavior in various situations.

Bowlby (1982) theorized that the attachment system had an adaptive evolutionary purpose. Human infants are born helpless, and are dependent on their mothers to meet all of their physiological needs. Therefore, maintaining proximity to the mother would enhance a young child's chances of survival. Attachment behavior was designed to maintain proximity, and engage the child's mother in providing protection and nurturance.

Attachment behavior is any form of behavior that results in a person attaining or maintaining proximity to some other clearly identified individual who is conceived as better able to cope with the world. ...for a person to know that an attachment figure is available and responsive gives him a strong and pervasive feeling of security, and so encourages him to value and continue the relationship. Whilst attachment behavior is at its most obvious in early childhood, it can be observed throughout the life cycle, especially in emergencies. Since it is seen in virtually all human beings (though in varying patterns), it is regarded as an integral part of human nature and one we share (to varying extent) with members of other species. The biological function attributed to it is that of protection. To remain within easy access of a familiar individual known to be ready and willing to come to our aid in an emergency is clearly a good insurance policy—whatever our age. (Bowlby, 1988, pp. 26–27).

**Mary Ainsworth.** In 1950, Bowlby hired Mary Ainsworth, an American-Canadian developmental psychologist, to assist with his continuing investigation of the effects of maternal separation on child development. While Ainsworth worked with Bowlby in London for only a short period, she became one of his most important long-term collaborators. Ainsworth's work (Ainsworth, 1967; Ainsworth, Blehar, Waters, & Wall, 1978) made significant contributions to our understanding of the development of attachment within the mother-child dyad, the different types or styles of attachment that children develop, and assessment of those attachment styles.

Ainsworth's early research on attachment involved detailed, long-term observations of mother-infant dyads, first in Uganda and later in the United States (Ainsworth, 1967; Ainsworth, Blehar, Waters, & Wall, 1978). In the early 1950s, she and her colleagues in Uganda observed 26 mother-infant dyads over the course of nine months (Ainsworth, 1967). When she moved



back to the United States to take a position at Johns Hopkins University, Ainsworth conducted a similar study, known as the Baltimore Project (Ainsworth et al., 1978), in which she and her colleagues conducted 18 four-hour in-home observations on mother-infant dyads during the child's first year of life. The results of these studies were detailed descriptions of the various sequences of behaviors that characterized a child's development of attachment to her mother or caregiver.

***The Strange Situation.*** During the Baltimore Project, Ainsworth developed an assessment technique known as the Strange Situation Procedure (SSP), designed to evoke in the laboratory the attachment behaviors that her teams had observed in home visits (Ainsworth et al., 1978). This half-hour procedure involved the mother, the child, and a "stranger" (one of the researchers) and was conducted in a laboratory playroom. It had seven episodes, each lasting approximately three minutes: 1) child and mother were together in room; 2) stranger entered; child, mother, and stranger were together in room; 3) mother left room; child and stranger were together in room; 4) stranger left and mother returned; child and mother were together in room; 5) mother left; child was completely alone in room; 6) stranger returned; child and stranger were together in room; and 7) stranger left and mother returned; child and mother were together in room. While the researchers were interested in the child's exploration of the toys in the playroom and her willingness to interact with the stranger, they paid special attention to the child's behavior when reunited with her mother after the two brief separations (episodes 4 and 7). During those episodes, the researchers recorded four types of behavior on the part of the child: proximity and contact seeking, contact maintaining, avoidance of proximity and contact, and resistance to contact and comforting.

***Childhood attachment styles.*** Based on the behaviors that children exhibited during the SSP, Ainsworth and her colleagues identified three distinct patterns or styles of attachment behavior, which Ainsworth termed *secure* (group B), *avoidant* insecure (group A), and *ambivalent* (or *resistant*) insecure (group C) (Ainsworth et al., 1978). Each of these styles represented a strategy that the children had developed, in response to their mothers' behaviors toward them, for meeting their proximity and dependency needs. Ainsworth et al. (1978) found that 63% of children had secure attachments, 21% anxious-avoidant insecure, and 16% ambivalent/resistant insecure. Ainsworth also identified qualities of a mother's behavior toward her child that she believed led the child to adopt a particular attachment style.

*Secure attachment (group B).* Children who had a secure attachment were distressed when their mothers left the room, and were happy and sought proximity when their mothers returned (Ainsworth et al., 1978). They explored the toys in the playroom when their mothers were present. While they were friendly with the stranger when their mothers were present, they avoided the stranger when left alone with her. Children with secure attachments maintained contact and communication with their mothers whether they were content or distressed. Securely attached children were believed to have mothers who were sensitive and timely in responding their children's bids for proximity, contact, and nurturance. These children had learned to trust that their expressions of distress and dependency would be met.

*Avoidant insecure attachment (group A).* Children who had an avoidant attachment showed little or no distress when their mothers left the room, and showed little interest or proximity-seeking behavior when she returned (Ainsworth et al., 1978). These children showed no avoidance of the stranger when left alone with her. The mother and the stranger were equally able to comfort the child. Initially, Ainsworth's team thought that this behavior indicated that

these children were precociously independent. However, when researchers began to monitor children's physiological signs during the SSP, they discovered that these apparently calm children had higher levels of physiological arousal, corresponding to higher levels of anxiety, than securely attached children who were visibly distressed. Avoidantly attached children were believed to have mothers who rejected their children's dependency needs and distress, although they might support their children's bids for exploration and independence. These children had learned that their mothers did not welcome expressions of distress and dependency, and they adapted by hiding their feelings of anxiety in order to maintain proximity.

*Ambivalent/resistant insecure attachment (group C).* Children who had an ambivalent/resistant attachment became quite distressed when their mothers left the room (Ainsworth et al., 1978). When their mothers returned, they initially approached or sought proximity to her, but resisted contact and comforting. They showed less exploration of the playroom when their mothers were present than securely attached children. They were avoidant and fearful of the stranger, whether or not their mother was present. They cried more than securely attached children. Ambivalently attached children were believed to have mothers who were inattentive and inconsistent in responding to their children. These children had learned that expressing greater distress and dependency (crying and clinging) would eventually lead to the desired response from their mothers, and they adapted their behavior accordingly to maintain proximity.

**Internal working models.** One of the most significant aspects of a child's primary attachment relationships is that they form the basis for the development of *internal working models* or *representational models* of the self and others (Bowlby, 1982). Internal working models are cognitive frameworks or schemas that inform an individual's expectations regarding

close relationships throughout life, with friends, teachers, lovers and spouses, bosses and coworkers, and one's own children. Working models have three main components: mental representations of other people, mental representations of self, and mental representations of self and others in the world. In a secure working model, others are seen as trustworthy and available, the self is seen as worthwhile, and the self is seen as effective in interacting with others and the world. A person who has a secure attachment "is likely to possess a representational model of attachment figures(s) as being available, responsive, and helpful" (Bowlby, 1982, p. 242). As children grow into adults, their internal working models become part of their adult attachment styles or attachment states of mind.

**Mary Main.** Psychologist Mary Main, a student of Ainsworth's, contributed to attachment theory both by elaborating on the classifications of children's attachment styles, and by extending the understanding of attachment styles into adulthood (Hesse & Main, 2000). Main identified a fourth childhood attachment style, termed *disorganized/disoriented* (group D). She also identified adult attachment styles corresponding to childhood attachment styles, and developed an instrument, the Adult Attachment Interview (AAI), for assessing them.

***Disorganized/disoriented attachment (group D).*** Main identified the disorganized/disoriented attachment style after researchers realized that they were unable to classify some infants using the three categories (e.g., secure, avoidant, or ambivalent/resistant) then available (Hesse & Main, 2000). In observations of maltreated infants in the early 1980s, researchers reported difficulties classifying the majority of infants; even in a large sample of low-risk children, Main and Weston (1981) were unable to classify 12.5% of the children. "Unclassifiable" infants exhibited a "diverse array of inexplicable, odd, disorganized, disoriented, or overtly conflicted behavior" (Hesse & Main, 2000, p. 1099). One child might

scream when the mother was out of the room, but quietly back away from her when she returned; another child who had been quite active might suddenly freeze or appear unconscious when the mother picked him up. The contradiction between behavior and movement patterns was termed *disorganized*; behavior that indicated a lack of orientation to the present was termed *disoriented*. Disorganized or disoriented behavior was often evident only in a single brief episode during the SSP, so infants classified as disorganized were also assigned the best-fitting alternate classification (e.g. disorganized/secure (D/B), disorganized/avoidant (D/A), or disorganized/ambivalent (D/C)).

As with the organized attachment styles, disorganized attachment is a child's response or adaptation to the mother's behavior. Hesse and Main (2000) asserted that "disorganized/disoriented behavior is expectable *whenever an infant is markedly frightened by its primary haven(s) of safety, i.e. the attachment figure(s)*" (p. 1102). This fear may result from the mother's maltreatment or neglect of the child, or may be the result of the mother's fearful or dissociative behavior related to her own unresolved childhood attachment experiences. Disorganization is the child's adaptation to a mother who is either *frightening* or *frightened*. While children with secure, avoidant, or ambivalent attachments have developed a strategy for meeting their attachment needs, children with disorganized attachments have not developed a particular strategy, or organization, for meeting their proximity and dependency needs.

**Adult Attachment Interview.** As part of a longitudinal study on attachment, Main developed an instrument for assessing the attachment style of the mothers of the children in the study (Main, 2000). The Adult Attachment Interview (AAI) is a semi-structured interview designed to gather information about an adult's early attachment relationships and experiences. The interviewer asks open-ended questions (e.g., "Would you try to describe your relationship

with your parents, starting as far back as you can remember?” or “When you were upset as a child, what would you do?”) and allows the respondent time to answer. While the interviewer attends to the content of the answers, the main focus is on the narrative coherence, the affective or emotional tone, and the self-reflection of the response. Main used the AAI to identify four adult attachment styles, each of which corresponds to a childhood attachment style: *autonomous*, *dismissive*, *preoccupied*, and *unresolved*.

*Autonomous secure attachment.* This style corresponds to secure childhood attachment (Main, 2000). Adults who have an autonomous adult attachment have memories of both good and bad attachment experiences, and value their attachment relationships. They exhibit moderate affect when describing difficult experiences. They are able to reflect on their experiences and show an understanding of and empathy for their attachment figures’ strengths and failings.

*Dismissive insecure attachment.* This style corresponds to avoidant childhood attachment (Main, 2000). Adults who have a dismissive attachment style have few strong memories of early attachment experiences, and tend to downplay the importance of attachment figures. They exhibit little affect when discussing difficult childhood experiences, and show little capacity for reflecting on their attachment experiences.

*Preoccupied insecure attachment.* This style corresponds to ambivalent/resistant childhood attachment (Main, 2000). Adults who had a preoccupied attachment style often expressed anger toward their attachment figures. They exhibited strong, sometimes overwhelming, affect when describing their attachment experiences, and showed little self-reflection about their attachment experiences.

*Unresolved insecure attachment.* This style corresponds to disorganized childhood attachment (Main, 2000). Adults who have an unresolved attachment style are inconsistent in

their descriptions of their attachment figures. Their narratives about attachment experiences have gaps and inconsistencies. Their affect when describing their attachment experiences is also inconsistent, and they show little capacity for self-reflection.

Main found a close correspondence between the adult attachment styles of mothers and the attachment styles of their children (Hesse & Main, 2000). Mothers who had an autonomous attachment style usually had securely attached children, and those with insecure styles tended to have insecurely attached children. More generally, mothers who had organized attachment styles, whether secure or insecure, generally had children whose attachments were organized; mothers with unresolved attachments almost always had children whose attachments were disorganized (Hesse & Main, 2000). These findings were the beginning of the work on the intergenerational transmission of attachment.

### **Additional Instruments for Assessing Attachment Security**

The Strange Situation Procedure was the first and, for several years, the only instrument for assessing attachment. However, the SSP is only useful for assessing attachment in very young children (12–18 months); by the time a child is 2 years old, he or she will typically have developed coping strategies that reduce obvious distress during separations, rendering the SSP unusable. In addition to the age limitations, the SSP is personnel-intensive, requires a complicated laboratory set-up, and is, by design, stressful for the child, and often for her mother as well. As interest in attachment research grew, researchers began to develop instruments for assessing children up to 4 or 5 years of age, that could be used in a variety of settings (such as during home visits or in clinics), that required fewer personnel (often a single researcher who either observed the child's behavior and completed the instrument, or assisted the mother in completing the instrument), and that would be less stressful for the child.

**Attachment Q-Sort.** Realizing the limitations of the Strange Situation Procedure, Waters and Dean (1985) developed the Attachment Q-Sort (AQS) as an alternate for assessing the security of attachment in infants and toddlers. The AQS consists of cards, in sets of 70, 90, 100, or 145, on which are written a behavioral characteristic of children aged 12–48 months. Cards include statements such as “child asks for and enjoys having mother hold, hug, and cuddle him,” “when child finds something new to play with, he carries it to mother or shows it to her from across room,” and “when child returns to mother after playing, he is sometimes fussy for no obvious reason” (Waters, 1987). The person performing the sort, either an observer or the mother, sorts the cards into nine piles from least characteristic to most characteristic of the child’s behavior. While the statements on most of the cards relate to attachment security, some statements are fillers added to facilitate sorting into equal piles. The child’s attachment security is calculated based on which security-related cards are placed in which pile, as compared to the sort for “the hypothetical most secure” infant or child (Waters, 1987).

The AQS was not designed to identify attachment styles, but rather to gauge the degree of attachment security along a continuum. To use the AQS to assess for security versus insecurity, Waters (1987) suggested setting a cut score that matches the typical attachment security/insecurity distribution for a particular population. In the middle-class, White populations sampled for early attachment research using the SSP, approximately 30% of children were insecurely attached. Setting a cut score of .30 on the AQS yields similar percentages of secure (above .30) and insecure (below .30) results for that population.

**Toddler Attachment Sort.** The Toddler Attachment Sort (TAS) was developed to meet the need for a simpler, more cost-effective assessment of attachment security and insecurity. This 45-item measure derived from the AQS uses computer software to score the sort and classify



attachment style (Andreassen & Fletcher, 2007). Thirty-nine cards are used to assess secure, avoidant, or ambivalent attachment; the remaining six screen for disorganized attachment. Cards are printed with statements describing the child's behavior in relationship to the parent, such as "child is comfortably cuddly, enjoys and is comforted by close physical contact with parent" and "child is demanding, fusses, cries, becomes angry if parent's responses are not immediate." The cards are presented in specific groups of three, and the observer or mother places one card of each triad into piles that are most characteristic of the child's behavior, somewhat characteristic of the child's behavior, and least characteristic of the child's behavior. The child's attachment style is determined by which cards were placed in which pile, as compared to sorts for the hypothetical most secure, avoidant, or ambivalent infant or child.

### **Functions of Attachment**

The main functions of attachment are to provide a sense of security for the child, to regulate arousal and emotions, to develop understanding and expression of emotions, and to create a base for exploring the world (Davis, 2011). Because the attachment system is an evolutionary adaptation to the infant's helplessness, maintaining the infant's feeling of safety and security is a primary goal of attachment. Infants signal distress or displeasure by appearing anxious, crying, and reaching for or approaching their mothers. If mothers respond to their distressed infants by speaking soothingly to them, picking them up and holding them close, the infants may continue to express distress for a short time, but will then stop crying, relax against their mothers' bodies, and breathe more regularly. Both the infant's and the mother's behaviors contribute to restoring the infant's sense of security.

A second function of attachment is to regulate arousal and affect (Atzil & Gendron, 2017). Newborn infants are unable to regulate basic physiological functions such as temperature

and respiration, a process known as *allostasis*. Mothers regulate their infants' allostasis through bio-behavioral *synchrony*, "the matching of behavior, affective states, and biological rhythms between parent and child, organized as an ongoing coherent pattern" (Atzil & Gendron, 2017, p. 162). Mothers regulate their infants' temperature by providing close physical contact that synchronizes their temperatures; they regulate arousal by speaking or singing to their infants, which helps to synchronize their heart rates. Early affective states, broadly conceptualized as pleasure and displeasure, are related to allostasis: Negative affect or displeasure indicates a loss of allostasis, while positive affect or pleasure indicates a return to allostasis.

Attachment relationships promote the understanding and expression of emotions. Infants learn the concept of emotions (e.g., happy, sad, angry) when their mothers label the infant's affective states during the process of co-regulation (Atzil & Gendron, 2017). Understanding and labeling one's emotions facilitates children's development of self-regulation. Having language for emotional experience allows children to share their own emotions with other people and eventually to understand other people's emotions. If a child's mother does not respond sensitively to all of the child's emotions, the child may not learn to notice, identify, and regulate the unacknowledged emotions. Bowlby (1988) stated that, "because a child's self-model is profoundly influenced by how his mother sees and treats him, whatever she fails to recognize in him he is likely to fail to recognize in himself" (p. 132).

As children grow, their attachment relationships provide a foundation for exploration and learning (Bowlby, 1988). Children's attachment and exploratory systems are interrelated; children who have secure attachments are able to explore the environment, knowing that their mothers are available for comfort and protection if needed. Ainsworth described these securely attached children as having a *secure base* for exploration (Ainsworth, 1978; Salter, 1940).

Children who are insecurely attached and do not trust that their mothers will provide needed protection may focus on maintaining proximity to their attachment figures at the expense of exploring.

### **Contextual Factors Affecting Development of Attachment**

As noted previously, Bassuk et al. (2015) hypothesized that the mental health of young children in homeless families may be mediated by their attachment to their mothers. If associations exist between housing status (e.g., homeless versus housed) or SES and attachment status, they may help us to understand the mental health problems that homeless children experience. Little research exists on attachment in homeless children; the most recent study (Easterbrooks & Graham, 1999) was published almost 20 years ago.

In this study of homeless and low-income housed families, Easterbrooks and Graham (1999) examined associations among housing status, parenting factors, and infant attachment. They studied a racially diverse sample of 55 homeless and 57 housed low-income mothers with infants in a northeastern U.S. city. The homeless dyads lived in emergency shelters or transitional housing; the minimum time in shelter was one week and the mean shelter time was eight weeks. The housed dyads, who had never been homeless, lived below the federal poverty line in public or privately owned housing. Children were 11–20 months old. Thirty-seven percent of the mothers were high school graduates. Easterbrooks and Graham assessed attachment using the mother as respondent on the Attachment Q-Sort (AQS). Parenting stressors were assessed using the Parenting Daily Hassles scale (PDH); parenting practices were assessed using the Parent Practices Scale (PPS). Maternal mental health was assessed using both the Symptom Check List (SCL-90) and the Center for Epidemiological Studies Depression scale (CES-D).

Easterbrooks and Graham (1999) found few differences between the homeless and housed children. The housed and homeless groups of children had the same mean attachment scores on the AQS; those scores were lower than mean scores from studies of middle-class children. Mean scores for parenting stressors (PDH) and parenting practices (PPS) were the same for both homeless and housed mothers. PDH mean scores were higher than the means for samples of primarily White, middle-class mothers. PPS scores were similar to scores for samples of largely low-income, single, Black mothers. The mothers in Easterbrooks and Graham's sample had overall high rates of depression: Two-thirds reported current symptoms in the clinical range, and 40% reported a lifetime history of major depression. Thirty-nine percent of mothers reported substance use problems. Ninety-six percent of the homeless mothers and 86% of the housed mothers had experienced violent victimization.

Easterbrooks and Graham (1999) found no significant associations among housing status, attachment security, and current maternal mental health. Among the total sample of homeless and housed dyads, attachment security was significantly associated only with fewer parenting stressors ( $p < .001$ ) and more favorable parenting practices ( $p < .001$ ). However, as noted above, the mean attachment security score for Easterbrooks and Graham's entire sample of children, all of whom were living in poverty, was lower than scores for middle-class children in the United States, and was similar to the score for a sample of children of impoverished, poorly educated mothers in Colombia (Posada et al., 1995). While they did not find the expected relationship between maternal mental health and attachment, the very high percentages of both homeless and housed mothers who had experienced violent victimization and/or substance dependency as well as depressive symptoms may have obscured any differences between the two groups of mothers, and may have been one factor in the lower mean attachment security scores.

Limitations of Easterbrooks and Graham's (1999) study include having a small sample from a single U.S. city. The homeless dyads had been homeless for a relatively brief time; longer periods of homelessness early in children's lives might have effects on attachment. Including a control group of middle-class dyads, rather than referring to attachment scores in previously published studies, might have provided comparisons that were more useful.

Poverty per se does not appear to be a determinant of attachment security. Both impoverished and affluent populations show wide variation in attachment security; in many studies of high-risk populations, the majority of infants are securely attached. Diener, Nievar, and Wright (2003) examined seven maternal, child, and contextual factors to determine their roles in the variability of attachment among families living in poverty. The variables studied as possible predictors of attachment security were maternal sensitivity, maternal depression, maternal efficacy (defined as a belief that parental input is critical to a child's learning and behavior), maternal play beliefs (defined as a belief that play is important in children's learning), child difficult temperament, availability of developmentally appropriate play materials, and social support. Diener et al.'s sample included 101 mother-child dyads participating in a home visiting program in a large city. Children were aged 12–57 months; 53% were female. Sixty-five percent of the families were Hispanic, 26% were White, 6% were Black, 2% were Native American, and 1% were Asian. Sixty percent of the mothers were married. Among the mothers, 53% had up to an 8th grade education, 22% had less than a high school education, 32% were high school graduates or had a GED, and 15% had some college education. Diener et al. assessed attachment using the mother as respondent on the AQS. They assessed the seven hypothesized predictor variables using items from the Home Observation for the Measurement of the

Environment (HOME), the Parent Stress Index (PSI), and the Parental Involvement and Efficacy Scale (PIE).

Diener et al. (2003) found significant associations among attachment security and several demographic and predictor variables. Attachment security was positively associated with maternal education ( $p < .01$ ), maternal sensitivity ( $p < .05$ ), maternal play beliefs ( $p < .01$ ), and provision of appropriate play materials ( $p < .001$ ), and negatively associated with maternal depression ( $p < .001$ ) and child difficult temperament ( $p < .01$ ). Examining the joint contributions of all variables that were individually associated with attachment security, Diener et al. found that maternal education ( $p < .01$ ), maternal depression ( $p < .05$ ), and appropriate play materials ( $p < .01$ ) were significant predictors of attachment security.

Combining scores for all the predictor variables, Diener et al. (2003) found that children in families with greater cumulative resources or assets had, on average, higher attachment security ( $p < .001$ ) than children in families with lower cumulative assets. Dividing the participants into three equal groups with the lowest, middle, and highest cumulative asset scores, Diener et al. found that children in the highest asset group had a mean AQS score that was similar to mean scores in middle-class populations, and significantly higher ( $p = .02$ ) than the mean AQS score of children in the lowest asset group.

Diener et al.'s (2003) findings indicated that, in terms of fostering attachment security in children, families living in poverty are not a homogenous population. By helping to explain the variability in attachment security among children living in poverty, the findings suggested promising targets for interventions: treating maternal depression, supporting further education for poorly educated mothers, and providing developmentally enriching toys to low-income families.

Limitations of Diener et al.'s (2003) study included having a small sample from a single U.S. city, which may reduce the generalizability of the findings. Also, when constructing a regression model to determine the contributions of variables to attachment security, the researchers' ordering of the variables was based on their hypotheses about the variables' importance, which may have been incorrect. One strength of the study was the detailed data on maternal education, which included a category for mothers with an 8th grade education or less; many studies combined all mothers who had not completed high school into a single group.

### **Effects of Trauma on Attachment Security**

Traumatic experiences share several characteristics: they threaten a person's physical or psychological wellbeing; they are emotionally overwhelming, evoking intense feelings of terror, lack of control, and helplessness; and they change the way that people experience themselves, other people, and the world (Guarino, 2014). According to the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–3; Zero to Three, 1999), trauma in young children may be related to one or more specific events or to ongoing chronic stress:

These might include an infant or toddler's direct experience, witnessing, or confrontation with an event or events that involve actual or threatened death or serious injury to the child or others, *or a threat to the psychological or physical integrity of the child or others*. The traumatic event may be a sudden and unexpected event (e.g., earthquake, terrorist attack, mauling by an animal); a series of connected events (e.g., repeated air raids); or a chronic, enduring situation (e.g., chronic battering or sexual abuse). The nature of the child's symptoms must be understood in the context of the trauma, the child's own personality characteristics, and *his or her caregivers' ability to help the child*

*cope, in terms of a sense of protection and safety*, as well as working through the experience. (p. 19, italics added)

In the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; American Psychiatric Association, 2013), trauma is defined relative to physical experiences or threats:

Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s). (p. 271)

For children under the age of 6, DSM-5 limits trauma to directly experiencing the event(s), witnessing the event(s) occurring to a parent or caregiver, or learning about the event(s) occurring to a parent or caregiver. While DSM-5 defines trauma as a response to damage or threats to one's own or another's physical integrity, DC:0–3's broader definition also includes threats to psychological integrity.

Lieberman (2004) noted that some events that are traumatic to a child may not induce trauma in an adult. While an adult may not be traumatized by a painful medical procedure because he or she understands its necessity, a young child who is unable to comprehend that need may find the procedure traumatic. Trauma in children must be understood in terms of children's developmental capacities at various ages. Lieberman provided the example of a mother and child who are separated for a week: A one-year-old may experience the separation as



a threat to her or his survival, while an older toddler who has the cognitive ability to understand that the mother will return may experience the separation as stressful, but not traumatic.

Some experiences may be traumatic for both the child and the mother (Lieberman, 2004). Witnessing domestic violence perpetrated against the mother may traumatize the child. Witnessing a traumatic event that the child has experienced, such as abuse by the other parent or a near-fatal accident, may also lead to trauma in the parent.

A young child's ability to recover emotionally from the effects of trauma depends largely on the quality of the attachment relationship with his or her mother, and the mother's attunement to the child's trauma responses (Lieberman, 2004). When young children are traumatized, their trauma responses or symptoms may include repetitive traumatic play, reenactment of the trauma, traumatic dreams, and physiological and emotional dysregulation (Lieberman & Van Horn, 2011). The child's trauma responses may distress the mother, and her experience of trauma in direct response to events that also traumatized her child may limit her ability to respond sensitively to the child.

Young children are exposed to higher rates of maltreatment than older children; Those who have experienced maltreatment, whether physical or psychological, evidence much higher rates of disorganized attachment than disadvantaged children who have not experienced maltreatment. Cicchetti, Rogosch, and Toth (2006) used the SSP to assess attachment security in a sample of maltreated one-year-old infants referred for treatment by child protective services ( $n = 137$ ) and a low-income non-maltreatment control group ( $n = 52$ ). Of the maltreatment group children, 66.4% had experienced maltreatment (e.g., neglect, physical abuse, or emotional abuse) during the first year of life; the remaining 33.6% lived in families in which a sibling had experienced maltreatment. Cicchetti et al. found that 89.8% of the maltreatment group children

had a disorganized attachment, compared to 42.3% of the low-income non-maltreatment group. Only one child (0.8%) in the maltreatment group had a secure attachment, compared to 32.7% of children in the non-maltreatment group. In the maltreatment group, 5.8% of children had avoidant attachment and 3.6% had ambivalent attachment, compared to 7.7% and 17.3% respectively of the non-maltreatment group. The rate of secure attachment was lower, and disorganized attachment higher, in Cicchetti et al.'s low-income non-maltreatment group than in a middle-class population studied by Toth, Rogosch, Manly, and Cicchetti (2006).

### **Effects of Attachment Insecurity on Children's Mental Health**

While a variety of individual, familial and contextual factors are associated with children's emotional and behavioral functioning, the role of attachment security in children's development of self-regulation is salient with regard children's mental health. Within secure attachment relationships, children learn to understand and regulate their emotions and impulses. Conversely, children who have insecure attachment relationships may develop maladaptive or ineffective regulation skills. Insecurely attached children, who either hide or overexpress their needs for proximity and protection within their attachment relationships, may be more likely than securely attached children to develop internalizing problems (related to overregulation) or externalizing problems (related to poor regulation).

A large body of research literature exists that examines the relationship between attachment security and externalizing psychopathology; study methodologies have varied, as have findings on effects, including effect sizes. Fearon, Bakermans-Kranenburg, van IJzendoorn, Lapsley, and Roisman (2010) conducted a series of meta-analyses using 69 samples ( $n = 5,947$ ) from 53 studies published between 1984 and 2007 to explore the relationship between attachment insecurity and externalizing behaviors. The studies included in the meta-analysis

reported on children 12 years of age or younger; they addressed only externalizing behavior rather than overall psychopathology, used observational measures of attachment (e.g., SSP, AQS, etc.), and used observational, diagnostic, and parent-report measures (e.g., CBCL) of externalizing behavior. In a comparison of all categories of insecure attachment with secure attachment, Fearon et al. (2010) found a significant effect size ( $d = .31, p < .01$ ): On average, children rated as insecure exhibited higher levels of externalizing behaviors than children rated as secure. Although small, the effect size was robust; the *fail-safe number* (i.e., the number of studies with null results needed to reduce the effect to non-significance) was 1,700. Interestingly, gender was a significant moderator: While samples of boys only and mixed samples had effect sizes similar to the overall meta-analysis, the effect sizes were insignificant in samples of girls only.

Fearon et al. (2010) next examined each category of attachment insecurity separately. Using 34 studies ( $n = 3,778$ ), they found a significant effect ( $d = .34, p < .01$ ) for the association between disorganized attachment and higher mean levels of externalizing behaviors. The fail-safe number of 407 studies indicated that the finding was robust. Again using 34 studies ( $n = 3,675$ ), they found that children with avoidant attachment showed, on average, slightly higher levels of externalizing behavior ( $d = .12, p < .01$ ) than securely attached children. However, the fail-safe number was 24 studies, indicating a less robust finding. No significant difference in externalizing behaviors was found between securely and ambivalently attached children. In discussing their findings, Fearon et al. noted that only four of the studies included in their meta-analysis were conducted with primarily racial and ethnic minority families. Additionally, only 14 of the 69 samples included low-SES families; SES was not found to be a moderator.

A large body of literature also exists that examines the relationship between attachment security and internalizing psychopathology; research findings have been varied. Madigan, Atkinson, Laurin, and Benoit (2013) conducted a series of meta-analyses using 60 studies ( $n = 5,236$ ) to explore the relationship between attachment insecurity and internalizing behaviors. Studies included in the meta-analysis addressed internalizing behavior rather than overall psychopathology, used observational measures of attachment (e.g., SSP, AQS, etc.), and used observations, parent-report, or teacher-report measures (e.g., CBCL) of internalizing behavior. When comparing all categories of insecure attachment with secure attachment, Madigan et al. (2010) found a significant, small-to-medium effect size ( $d = .37, p < .001$ ) linking insecure attachment and increased internalizing behaviors. However, when they adjusted for publication bias in some studies, the effect size was smaller ( $d = .19, p < .01$ ). Although small, the adjusted effect size was robust, with a fail-safe number of 1,979.

Madigan et al. (2013) then explored moderators of the association between attachment security and internalizing behavior. Using 35 studies that also provided measures of externalizing behavior, they found stronger associations between insecure attachment and internalizing behavior in samples with higher mean externalizing scores ( $p < .02$ ). Gender was also a significant moderator ( $p < .01$ ): While samples of girls only had an insignificant effect size, the effect size increased linearly according to percentage of boys in the study to a large significant effect size in samples of boys only.

Madigan et al. (2013) also examined categories of attachment organization and insecurity separately. Using 20 studies ( $n = 2,679$ ), and comparing disorganized and organized (i.e., secure, avoidant, or ambivalent) attachments, they found a small effect size ( $d = .20$ ) for the association between disorganized attachment and higher mean levels of internalizing behaviors. However,

this finding was not robust, with a fail-safe number of 74 studies. Using 21 studies ( $n = 1,852$ ), they found that children with avoidant attachment showed, on average, higher levels of internalizing behavior ( $d = .29$ ) than securely attached children. However, the fail-safe number was 79 studies, indicating a less robust finding. Using 21 studies ( $n = 1,823$ ), no significant difference in internalizing behaviors was found between securely and ambivalently attached children.

By the age of 2 years, children with insecure attachments exhibit on average greater internalizing and externalizing symptoms than their securely attached peers. Yoon et al. (2017) examined the risk factors and developmental trajectories of internalizing and externalizing symptoms in young children involved in the child welfare system. Their sample was drawn from the National Survey of Child and Adolescent Well-Being II (NSCAW-II), a national longitudinal study of children involved in the child welfare system. Children in the sample ( $n = 329$ ) were 2 years old at the beginning of the NSCAW-II; 41% of the children were non-Hispanic White, 27.4% were non-Hispanic Black, 27.10% were Hispanic, and 4.6% were of other races. Data were collected at baseline and at follow-ups 18 months and 36 months later. At baseline, child welfare caseworkers reported on the child's maltreatment experiences (physical abuse, emotional abuse, and neglect), caregiver mental health, caregiver alcohol and drug use, out-of-home placement, and exposure to intimate partner violence (IPV). Caregiver-child attachment was measured using an insecure attachment scale developed by the National Longitudinal Survey of Youth for children aged 2 to 6 years old. The scale consists of these seven items: trouble calming when upset; child stays close to caregiver during play; child copies how caregiver acts; child gets upset when caregiver leaves room, child is demanding and impatient when caregiver is busy; child gets worried when caregiver is upset and tries to help; child wants caregiver's help with

activities. Through caregiver reports on these items, the scale assessed the child's emotional and behavioral style and the relationship with the caregiver. Of the sample children, 21.7% had an insecure attachment. Children's behavior symptoms were measured at each wave using the internalizing and externalizing subscales of the Child Behavior Checklist (CBCL 1.5-5).

Yoon et al. (2017) found that insecure attachment measured at age 2 was associated with higher baseline levels of both internalizing and externalizing symptoms at age 2 ( $p < .001$  on both subscales) than secure attachment. However, they did not find associations between attachment security and changes in internalizing or externalizing symptoms over time. Higher baseline levels of internalizing and externalizing symptoms were also associated with exposure to IPV ( $p < .01$  for internalizing symptoms and  $p < .001$  for externalizing symptoms), child neglect ( $p < .05$  for internalizing and  $p < .01$  for externalizing), and caregiver mental health problems ( $p < .05$  for both internalizing and externalizing symptoms). Exposure to IPV predicted the rate of change in externalizing symptoms ( $p < .05$ ), while out-of-home care and caregiver drug use predicted the rate of change in internalizing symptoms ( $p < .05$  and  $p < .01$  respectively). More generally, higher initial levels of internalizing symptoms were associated with higher initial levels of externalizing symptoms ( $p < .001$ ). On average, internalizing symptoms remained stable. Contrary to Yoon et al.'s hypotheses, externalizing symptoms decreased over time ( $p < .05$ ); they speculated that this decrease may have been related to services children and families received after entering the child welfare system.

A major strength of Yoon et al.'s (2017) study was their use of NSCAW-II, which allowed them to examine children's emotional/behavioral trajectories over time using a large dataset. Additionally, their use of the internalizing and externalizing subscales of the CBCL led to more detailed findings about the relationships between young children's experiences and their

behavioral symptoms. A limitation was that the NSCAW-II's measure of attachment security did not distinguish between avoidant, ambivalent/resistant, and disorganized attachment. Previous research has shown associations between internalizing symptoms and avoidant attachment, but not for ambivalent or disorganized attachment (Madigan et al., 2013). Further, as noted earlier, externalizing symptoms were more strongly associated with disorganized attachment than with ambivalent or avoidant attachment (Fearon et al., 2010). An analysis using the specific categories of insecure attachment might have yielded more nuanced and robust findings.

Attachment security appears to be associated with the trajectory of children's emotional and behavioral problems through middle childhood. Using data from four waves (e.g., years one, three, five, and nine) of the FFCW (as described in Chapter III), Keyser et al. (2017) studied the relationships among children's emotional and behavioral problems and several maternal and child factors: maternal depression during the children's first year, maternal spanking during the children's first year, maternal parenting stress when the children were three years old, children's cognitive abilities at age three, the children's attachment security at age three, and involvement with the child welfare system before children were five years old. Spanking during the first year and child welfare involvement were measured by maternal self-report. Using the TAS, 76% ( $n = 1719$ ) of the children were classified as securely attached, and 24% ( $n = 549$ ) as insecurely attached.

Several of the factors that Keyser et al. (2017) studied were associated with each other and with children's mean total CBCL scores. Spanking in the first year of the child's life was significantly associated ( $p < .001$  in all analyses) with attachment insecurity at age three, maternal depression in the child's first year, and child welfare involvement before age five. Insecure attachment, maternal depression, maternal spanking, and child welfare system

involvement were significantly associated ( $p < .001$  in all analyses) with higher mean total CBCL scores.

Exploring the associations over time, Keyser et al. (2017) found that the association between attachment security at age three and children's emotional and behavioral problems increased from ages three to nine ( $p < .001$ ). Compared to insecurely attached children, children who had a secure attachment had, on average, a flatter CBCL score trajectory: They were less likely to show behavioral and emotional problems at each successive survey wave. Conversely, insecurely attached children were, on average, at greater risk than securely attached children for emotional and behavioral problems as they became older.

A major strength of Keyser et al.'s (2017) study was their use of the FFCW ( $n = 4,898$ ), which allowed them to examine children's emotional/behavioral trajectories over time using a large data set. A limitation of this study was Keyser et al.'s use of all available data for each of the factors they studied, even though the number of respondents differed. For instance, fewer than half ( $n = 2,268$ , or 46.3%) of the original birth cohort families participated in the in-home interview during which attachment was assessed; the relationships between attachment security and CBCL scores in the 53.7% of children who were not assessed for attachment might have been significantly different. A more rigorous approach would have been to conduct all analyses only using the families who participated in the attachment assessment; this also might have led to more nuanced and robust findings. Also, Keyser et al. used total CBCL scores rather than scores on the internalizing and externalizing subscales, and they combined the groups of children who had avoidant and ambivalent attachments into a single insecure attachment group; these decisions may well have limited the specificity of their findings.

## **Summary**



Attachment is a fundamental developmental task of infancy and early childhood. It is the means by which children learn to regulate their emotions and arousal, communicate their emotions and thoughts to others, and engage in exploratory behavior knowing that their attachment figure is a secure base to whom they can return for support and comfort. Early attachment relationships are the mechanism by which children develop internal working models of others, themselves, and the world. These internal working models shape expectations of all future relationships.

When addressing the mental health needs of young homeless children, a therapist's primary goal should be to facilitate the optimal conditions for developing secure attachments. If the mother is able and willing to participate actively, this facilitation may take the form of interventions with the mother-child dyad to modify the mother's behavior and internal representations or internal working models of the child and of herself. If the mother is not capable of engagement, clinicians may instead choose an intervention in which the clinician serves as an attachment figure for the child, and perhaps for the mother as well. Chapter V is a review of several evidence-based mental health interventions that focus on attachment relationships, either between mothers and young children or between young children and their therapists. It also discusses the feasibility of using these interventions with young homeless children in homeless shelters or transitional housing.

## **CHAPTER V**

### **Interventions**

As discussed in Chapter IV, the attachment relationships that children form with their mothers or primary caregivers have lasting effects on their personality development and mental health. Through the mechanism of internal working models, attachment shapes the understanding and expectations that children develop of themselves, their relationships with other people, and their efficacy in the world (Bowlby, 1982). Inconsistent or rejecting parenting may lead to insecure attachment, while parenting by a frightening or frightened mother may result in disorganized attachment (Ainsworth et al., 1978; Hesse & Main, 2000). Trauma experienced by either the parent or the child may disrupt the attachment relationship (Lieberman, 2004). While homelessness is not directly associated with insecure attachment, rates of insecure and disorganized attachment are higher in homeless children and children living in poverty than in middle-class children (Diener et al., 2003; Easterbrooks & Graham, 1999). Additionally, vulnerabilities for family homelessness such as low maternal education, maternal depression, and maternal experiences of IPV are associated with attachment insecurity or disorganization in children (Cicchetti et al, 2006). Insecure or disorganized attachments in early childhood are associated with mental health problems as children grow (Fearon et al., 2010; Keyser et al., 2017; Madigan et al., 2013; Yoon et al., 2017).

This chapter is an attempt to answer the clinical social worker's question, "How can I help?" In this chapter, the question is further elaborated: Which intervention(s) might a clinical

social worker use in working with a homeless infant or young child and her or his mother to facilitate the development of secure attachment and to reduce the likelihood of insecure and/or disorganized attachment? This chapter includes a discussion of the approach for selecting interventions to review, descriptions of several mental health interventions that target either the parent-child attachment relationship or the child's development of an attachment relationship with a therapist, and a discussion of adaptations to the intervention models that might be required when using them with homeless families living in homeless shelter or transitional housing settings.

### **Selection of Interventions**

To select interventions for review, two databases of evidence-based practices were searched; both include mental health interventions for young children and families. These databases were the California Evidence-Based Clearinghouse for Child Welfare and the National Registry of Evidence-Based Programs and Practices. This section will describe the characteristics of each database, including the rating system used by each for assessing interventions.

The California Evidence-Based Clearinghouse for Child Welfare (CEBC; <http://www.cebc4cw.org/>) is a program registry of evidence-based practices found to be effective in improving outcomes for children and families involved in the child welfare system. The California Department of Social Services Office of Child Abuse Prevention funds the registry. The CEBC rates interventions on scientific reliability and relevance for the population of children who are receiving child welfare services. The CEBC requires that listed interventions have a manual that describes implementation; conform to at least one of 47 CEBC topic areas, which are grouped into seven core topics (e.g., anger management, domestic violence, and

substance abuse; behavior management including parent training; core child welfare services including placement and reunification; engagement and parent partnering programs; mental health; prevention and early intervention; support services for youth in the child welfare system); publish outcomes of research studies in peer-reviewed journals; and use reliable and valid outcome measures. The CEBC’s scientific reliability rating is based on the number of published rigorous randomized controlled trials (RCTs), and a post-test showing sustained effect in at least one RCT (“CEBC Scientific Rating Scale”, n.d.). A rating of 1 (*well supported by research evidence*) requires at minimum two published RCTs, one of which must have a one-year post-test. A rating of 2 (*supported by research evidence*) requires at minimum one published RCT, including a six-month post-test. A rating of 3 (*promising research evidence*) requires at minimum one published study that utilized a control (e.g., untreated group, placebo group, matched wait list group) and reported the intervention’s benefit over the control. The CEBC also provides a relevance rating for its listed interventions. A relevance rating of *high* indicates a program that “was designed, or is commonly used, to meet the needs of children, youth, young adults, and/or families receiving child welfare services” (“CEBC Child Welfare System Relevance Levels”, n.d., para. 3); a *medium* rating indicates that the populations for which the program was designed or commonly used are “similar to child welfare populations (i.e., in history, demographics, or presenting problems) and likely include current and former child welfare services recipients” (“CEBC Child Welfare System Relevance Levels”, n.d., para. 4).

The National Registry of Evidence-Based Programs and Practices (NREPP; <https://nrepp.samhsa.gov/landing.aspx>) is a review system “designed to provide the public with reliable information on mental health and substance use interventions” (“About NREPP”, n.d., para. 1). The Substance Abuse and Mental Health Services Administration (SAMHSA), part of

the U.S. Department of Health and Human Services (HHS), funds NREPP. NREPP currently provides reviews for 571 programs. NREPP changed its criteria for reviewing programs in September 2015, and has reviewed 215 programs under the new criteria, which include outcome evidence ratings based on published studies. The 356 programs reviewed between 2008 and 2015 are still listed on the website. NREPP stated in 2015 that re-review of these 356 programs under the new criteria: “will take place over the course of the next several years, depending on available resources” (“Notice regarding SAMHSA’s NREPP”, July 7, 2015, p. 38716); none of the programs has yet been re-reviewed.

NREPP’s outcome evidence ratings are based on four criteria: *rigor*, *effect size*, *program fidelity*, and *conceptual framework* (“Program Review Criteria”, n.d.). Rigor assesses the strength of the study methodology, and includes study design/assignment, threats to internal validity, measurement reliability and validity, and attrition. Effect size describes whether a program had an impact, the size of the impact, and whether it benefited the treatment group. Program fidelity denotes if the program was delivered as intended and to the target population. Conceptual framework addresses the clarity of a program’s components, including program goals, program activities, and theory of change. Programs are given evidence ratings of *effective*, *promising*, *ineffective*, or *inconclusive*.

**Registry search.** Because the CEBC focuses on programs that has been shown to benefit families and children in the child welfare system, it was searched for interventions that might benefit children who have experienced homelessness. Children who have experienced homelessness and children in the child welfare system share many characteristics (Zlotnick, 2009; Zlotnick, Tam, & Zerger, 2012). Both have lived in poverty, and have likely been exposed to a variety of stressors and traumas, including community violence, domestic violence, neglect

and maltreatment. Some children in the child welfare system have been homeless; children who are homeless are at higher risk than housed children for being removed from their mothers' care. Whether children have left their homes due to an eviction or removal by child protective services (CPS), they have likely experienced significant losses related to their homes, their personal belongings, their neighborhoods, family and friends, their social institutions, and the familial routines and rituals to which they were accustomed. Due to these similarities, interventions that have been deemed effective with children and families in the child welfare system are likely to be effective for homeless children living in shelter or transitional housing settings with their families.

The CEBC search focused on interventions in the Mental Health topic area that had scientific ratings of either 1 or 2, and relevance ratings of high or medium. The CEBC's mental health topic areas included attachment interventions; anxiety treatment; depression treatment; disruptive behavior treatment; infant and toddler mental health programs; and trauma treatment. The search yielded 36 interventions. Exclusion criteria included interventions designed exclusively for children over the age of six; interventions only with the parent rather than the child or the parent-child dyad; interventions that were not explicitly relational, focusing on either the child-parent dyad or the child-therapist relationship; interventions for educational settings; and interventions developed and studied outside of the United States. When applied, the exclusion criteria reduced the number of interventions to three: *Attachment and Biobehavioral Catch-Up* (ABC), *Child-Parent Psychotherapy* (CPP), and *Parent-Child Interaction Therapy* (PCIT). Although the CEBC identified *Child-Centered Play Therapy* (CCPT) and *Theraplay* as having scientific ratings of 3, they were among the few evidence-based mental health

interventions for children that have been studied in homeless or domestic violence shelter settings, so they were included in the review.

The NREPP's evidence ratings for these five interventions were then consulted to gauge the programs' value. Attachment and Biobehavioral Catch-up, Child-Centered Play Therapy and Theraplay have been reviewed since 2015, and are listed with outcome ratings of effective and promising in various domains, using NREPP's current criteria. Child-Parent Psychotherapy and Parent-Child Interaction Therapy are listed under NREPP's pre-2015 criteria, which included outcome listings provided by the intervention developers.

## **Interventions**

This section is a review of the mental health interventions identified in the database searches: Attachment and Biobehavioral Catch-up, Child-Centered Play Therapy, Child-Parent Psychotherapy, Parent-Child Interaction Therapy, and Theraplay. The review of each intervention includes the intervention's theoretical orientation and primary goals, and provides a brief description of the intervention process. The review also includes the settings in which the intervention is provided, the resources required to implement the intervention, and the training required to implement the intervention. Next, the evidence base for the intervention is discussed, including a brief review of relevant research literature. The review concludes with a discussion of issues related to implementing the intervention with homeless children and their families living in emergency shelters or transitional housing.

**Attachment and Biobehavioral Catch-up.** Attachment and Biobehavioral Catch-up (ABC) is a 10-week, manualized intervention designed for parents or caregivers of children at risk for neglect or maltreatment (Dozier, Meade, & Bernard, 2014). ABC was developed for and

has been studied with children from 6 to 24 months of age. Dozier et al. (2014) reported that they are working on adapting ABC for use with children up to 36 months.

***Intervention goals.*** The ABC intervention has three targeted behavioral goals for the mother, and three outcome goals for the child (Dozier et al., 2014). The behavioral goals for the mother are these: increasing the mother's nurturing behaviors when the child is distressed and may behave in ways that push the mother away; increasing the mother's responsive, synchronous behaviors when the child is not distressed, which the intervention describes as "following the child's lead" and "showing delight in the child"; and reducing the mother's behaviors that may be frightening or intrusive to the child (Dozier et al., 2014, p. 50). The outcome goals for the child are increasing the child's attachment security and organization, thereby decreasing attachment disorganization; increasing the child's physiological and behavioral regulation; and increasing the child's sense of efficacy and self-esteem.

***Intervention process.*** The ABC treatment manual provides didactic material related to attachment and its effects on child development and behavior; the *parent coach* (ABC's term for the clinician) focuses on covering specific aspects of this material with the mother during each session (Dozier et al., 2014). However, the developers of the intervention believe that the main mechanism of treatment is *in the moment comments* (Dozier et al., 2014, p. 48). These are comments from the parent coach in response to observed interactions between the mother and child that can be linked to one of the three targeted behavioral goals. When the parent coach sees such an interaction, she identifies the child's behavior and the mother's response, notes how that response relates to one of the target goals, and suggests how the mother's behavior might affect the child's understanding of herself, the mother, or the world. Dozier et al. (2014) elaborated:



For example, the following illustrates a comment that meets all three criteria: (in response to parent taking a toy that child handed her) “He handed you that toy and you took it right from him (i.e., description). That’s a great example of you following his lead (i.e., target). That lets him know he has an effect on the world” (i.e., effect on child). (p. 48)

The 10 sessions are organized in pairs, with each pair focusing on a specific behavioral goal (Dozier et al., 2014). The topics are introduced in an order designed to be most comfortable for the mother, starting with responding with nurturance to a child’s distress, and working toward material that may be more difficult. This more challenging material includes identifying ways in which the mother’s behavior may be distressing or frightening to the child, and exploring how the mother’s childhood experiences may affect her parenting.

Sessions 1 and 2 focus on providing nurturance when a child is distressed (Dozier et al., 2014). A child must believe that the parent will be available to provide reassurance and protection, even if the child is difficult to soothe or behaves in ways that push the parent away. The parent coach shows video clips of children who behave in avoidant, ambivalent or disorganized ways to illustrate the difficulties of responding in a nurturing manner to children who may appear not to need reassurance, and to help the parent learn to override the feelings and reactions elicited by such behavior. Using in the moment comments, the coach encourages and supports the mother to respond with nurturance to her child’s distress during sessions.

Sessions 3 and 4 aim at increasing the parent’s responsive or synchronous parenting behaviors when the child is not distressed (Dozier et al., 2014), behavior described as following the child’s lead with delight. Parents work on learning to follow the child’s lead in activities that include playing with blocks in session 3, and making pudding together in session 4. Coaches use video clips of other parents engaging in the same activities to illustrate the difference between

following and leading in play. During the activities, parent coaches use in the moment comments to identify times when the parent follows the lead, and suggest other ways she might respond to the child. Later, a video recording of the sessions is used to further reinforce parents' understanding of interactional synchrony.

Sessions 5 and 6 focus on reducing parental behaviors that are intrusive or frightening to the child (Dozier et al., 2014). First, the coach discusses ways in which a parent's intrusive behavior can be overwhelming for the child, and helps parents to notice children's cues in videos of other parents being intrusive or frightening with their children. Activities with puppets and noisy toys are used because they may elicit intrusive and/or frightening behavior. The parent coach uses in the moment comments to help the parent read and respond to the child's signals for engagement and disengagement. Coaches ask parents to consider ways in which they were frightened as children, and well as ways in which their behavior may frighten their own children. The parent coach discusses the challenge of being aware that a behavior is frightening or recognizing the consequences of frightening behavior.

Sessions 7 and 8 focus on recognizing and overriding parents' "voices from the past." (Dozier et al., 2014, p. 51). Parent coaches discuss the issues and experiences that parents had with their own caregivers that may negatively influence the parents' behavior with their own children. When parents become conscious of these influences, they can learn to override them and behave in more nurturing or responsive ways. The parent coach works with the parent to develop strategies for overriding automatic behaviors and responding in ways that meet the child's needs. As in previous sessions, the parent coach uses video clips of other parents to illustrate the material, and makes in the moment comments regarding the parent's behavior

toward the child. Dozier et al. (2014) discussed the therapeutic value of linking voices from the past and the parent's current behavior:

It can be powerful to link the discussion about “voices from the past” to what is occurring between the parent and child during the session. For example, a parent might be soothing her crying child as she is describing how her mother would ignore her distress or respond by telling her she was spoiled. In this case, a parent coach might point out the parent's strengths in recognizing her voices from the past and in making active efforts to behave differently (commenting specifically on her ability to be nurturing in the moment). (p. 51)

Sessions 9 and 10 focus on integrating intervention gains (Dozier et al., 2014). The didactic materials in these sessions cover nurturing touch and young children's emotions. The coach continues to reinforce the intervention targets: nurturing when the child is distressed, following the child's lead and delighting in the child, and avoiding frightening or intrusive behavior. In the final session, coach and parent review session videos showing progress in each of the three target areas, and celebrate gains made.

***Setting.*** ABC is a home-visiting intervention (Dozier et al., 2014). ABC holds that to understand the context of the mother-child relationship, the parent coach must provide treatment where the family lives, whether in permanent housing, in a shelter, or in another temporary housing situation.

***Resources.*** The resources required to implement ABC are equipment for making and viewing videos. ABC makes use of whatever toys or play resources can be found in the family's living quarters.

***Provider requirements.*** A graduate education is not required for training as an ABC parent coach. While most parent coaches are master's or doctoral level clinicians, individuals

with bachelor's degrees or limited college experience have been trained. A screening interview is required prior to training. The 3-day ABC parent coach training is provided at the University of Delaware ("Training in ABC", n.d.). Parent coaches must complete one year of weekly supervision, including both group supervision and individual supervision) to become a certified ABC parent coach. The manual for implementing ABC is available only to people who enroll in the training.

***Evidence base for intervention.*** ABC is listed in both the CEBC and NREPP registries of evidence-based interventions. The CEBC lists ABC as an intervention for infant and toddler mental health (0–3), rating its scientific reliability as 1, and its relevance for child welfare as high ("Attachment and Biobehavioral Catch-up [ABC]", 2016). Listing ABC under its new criteria, NREPP gives ABC an evidence rating of effective for cognitive functioning, disruptive behavior disorders and symptoms, and non-specific mental health disorders and symptoms; it gives a promising rating for family cohesion, parenting practices, self-concept, and physical health conditions and symptoms ("Attachment and Biobehavioral Catch-up [ABC] Program Description", 2016).

ABC has been studied primarily with parent-child dyads in which the child either has experienced maltreatment or is at risk for maltreatment. Study samples have included foster/adoptive parent-child dyads in which the child has behavioral and attachment problems, and birthparent-child dyads in high-risk families (Bernard et al., 2012; Yarger, Howe, & Dozier, 2016). Studies of more than 1000 mother-child dyads have been reported in published articles.

Children who received ABC were found to have lower rates of disorganized attachment and higher rates of secure attachment than those who received a control intervention (Bernard et al., 2012). Participants included 120 children and 113 parents (7 parents had two children

enrolled in the study) who were referred from agencies working with child protective services. All parents were enrolled in a program to divert children from foster care because of identified needs and/or concerns that children were at risk. The children were aged 1.7–21.4 months, and parents 15.7–47.0 years. Among the children, 61% were African American, 20% were biracial, 11% were White/Hispanic, and 8% were White/non-Hispanic; 61% of parents were African American, 15% were White/Hispanic, 15% were White/non-Hispanic, and 9% were biracial. Participants were randomly assigned to either the ABC intervention or to a control intervention, Developmental Education for Families (DEF). No significant group differences were found between the children and parents assigned to ABC and those assigned to DEF.

One month after completing the interventions, the parent-child dyads participated in the Strange Situation Procedure (SSP; Bernard et al., 2012). Children in the ABC intervention group showed lower rates of disorganized attachment than those in the DEF intervention ( $p < .01$ ), with 32% of ABC group children having disorganized attachment post-treatment as compared to 57% of the DEF group children. The effect size of this difference was medium ( $d = 0.52$ ). Similarly, rates of secure attachment in the ABC group of children were higher post-treatment than in the DEF group ( $p < .05$ ), with a medium effect size ( $d = 0.38$ ). While 52% of children in the ABC group had secure attachments, only 33% of those in the DEF group were securely attached. One limitation of this study was that the SSP was used with children older than the 24 months for which the procedure has been validated; however, an analysis of only the children who were between 12 months and 24 months showed similar results. The investigators conducted no pre-intervention assessment for attachment security or organization. While no significant demographic differences existed between the ABC intervention group and the DEF control group, and analysis of the SPP attachment classifications showed no associations with

demographic variables, differences in pre-intervention attachment security or organization between the two groups may have existed.

Yarger et al. (2016) noted that change in maternal behavior over the course of the ABC intervention appeared to be non-linear, with the majority of change occurring during the first half of the intervention. Mothers in the ABC intervention ( $n = 13$ ) showed greater rates of increased sensitivity and decreased intrusiveness during the first five sessions than during the second five. While the mean rate of change (or, slope) for sensitivity during the first five sessions was significantly different from zero ( $b = 0.22, p < .01$ ), the mean rate of change during the second half was not ( $b = 0.01, p = .82$ ). The mean rates of change for sensitivity in the first and second halves of treatment also differed from each other significantly ( $p = .03$ ). For intrusiveness, the mean rate of change during the first five sessions was significantly different from zero ( $b = -0.26, p < .01$ ); the rate of change during the second half was not ( $b = -0.03, p = .70$ ). The rates of change for intrusiveness in the first and second halves of treatment also differed from each other significantly on average ( $p = .03$ ).

Yarger et al.'s (2016) data showing a greater rate of change during the first half of the ABC intervention raise several questions. Would a five-session adaptation of ABC be as effective as the 10-session version, or are the additional five sessions needed to consolidate change? What is the fewest number of sessions that would prove effective? Would mothers and children who dropped out of the intervention at the midpoint gain as much from it as those who completed it? The finding that intrusiveness decreased more quickly during the first half of the intervention is surprising, as intrusiveness does not become a focus of the treatment until session 5, almost midway in the intervention.

Yarger et al.'s (2016) study had several limitations. The robustness of their finding on trajectory of change was limited by the small sample size ( $n = 13$ ) in the ABC intervention. Further research is needed to determine whether these findings are replicable. The study assessed only maternal behavior, and did not include an assessment of the child's response to the intervention. While the mother's behavioral changes may occur primarily during the first five sessions of ABC, the child's response, particularly a change in the child's attachment style, may require more time. Research into the effectiveness of a briefer version of ABC should include an assessment of the child's attachment status.

***Attachment and Biobehavioral Catch-up with homeless families.*** ABC is a 10-session intervention typically conducted in weekly sessions. The average stay in family shelters is seven weeks (Solari et al., 2016), so completing a standard course of ABC might be feasible for a many families in shelters, particularly if sessions were provided twice weekly. Since the goal of emergency shelters is to move families into more stable housing as quickly as possible, the brevity of the intervention would be appropriate. With families typically living in transitional housing from 11 to 15 months (Gubits et al., 2016), ABC also appears to be well suited for use as an intervention for families living in that setting. Although the model calls for 10 sessions, with the first six focused on the mother's three behavioral targets, Yarger et al.'s (2016) finding that the greatest change in maternal behavior occurred in the first five sessions suggests that even an interrupted or abbreviated treatment might benefit both the mother and child. The first sessions focus on the mother learning to behave with nurturance toward a child who is distressed; many aspects of a shelter setting might be distressing for an infant, including her mother's response to being there. Providing more frequent sessions (i.e., twice weekly rather than weekly) for families

in emergency shelters might allow them to complete the intervention; alternately, the parent coach might follow a family that exited the shelter to their new housing.

The ABC intervention model allows for, and even encourages, family members other than the mother and child to be present during sessions (Dozier et al., 2014). This might make it easier for a mother with more than one child to engage in treatment, and suggests that the model tolerates intrusion from others sharing the same space.

Dozier et al. (2014) recommended a post-test for attachment security using the SSP. While post-tests are important for clinical trials, they may be less important in non-research settings. However, as community mental health moves toward more standardized measures for assessing effectiveness of treatment, assessing post-treatment may be necessary in order to fund both training in and provision of the intervention. For clinicians working in shelter or transitional housing settings, having access to both a laboratory playroom and personnel trained in administering and coding the SSP is unlikely, short of involvement in a clinical trial. Clinicians might consider using one of the instruments described in Chapter IV, such as the AQS or TAQ, to assess attachment both pre- and post-intervention. One of ABC's attachment goals is to reduce or prevent disorganization, which the AQS does not assess, though it could be used to assess the strength of secure attachment. The TAQ could be used to assess both a young child's security and disorganization.

Training to become an ABC parent coach requires no prior clinical education and fewer classroom hours than many other intervention programs. Therefore, training in ABC may be an option for individuals with less formal education than licensed clinicians. In the current economic and political climate, in which future funding for mental health care for people living in poverty appears to be uncertain, either community mental health agencies or housing agencies



that manage shelters and transitional housing might choose to have interested unlicensed staff trained in implementing ABC.

**Child-Centered Play Therapy.** Child-centered Play Therapy (CCPT) is a manualized intervention for children from 3 to 10 years of age who are experiencing emotional, behavioral, and relational problems. In clinical settings, CCPT is typically conducted in 16–20 weekly 45-minute sessions (Ray & Landreth, 2015). In schools, CCPT may be conducted in twice-weekly 30-minute sessions over eight weeks (Ray & Landreth, 2015). Intensive versions, consisting of 12 sessions over two to three weeks for individuals or sibling pairs, have been conducted in domestic violence shelters (Kot, Landreth, & Giordano, 1998; Tyndall-Lind, Landreth, & Giordano, 2001). Initially developed in the 1940s by Virginia Axline as non-directive play therapy and based on Rogerian person-centered theory, CCPT holds that the primary therapeutic factor for change is the relationship between the therapist and the child (Ray & Landreth, 2015).

**Intervention goals.** The overarching goal of CCPT is to create conditions that support the child's potential to experience growth and integration (Ray & Landreth, 2015). Related to this broad goal are more specific objectives: the child will

develop a more positive self-concept, assume greater self-responsibility, become more self-directing, become more self-accepting, become more self-reliant, engage in self-determined decision making, experience a feeling of control, become sensitive to the process of coping, develop an internal source of evaluation, and become more trusting of self. (Landreth, 2012, pp. 84–85)

**Intervention process.** CCPT's posited mechanism of change is the relationship that the therapist offers to the child (Ray & Landreth, 2015). To create a therapeutic relationship with the child, the therapist must provide three conditions or attitudes: *congruence* or *genuineness*,

*unconditional positive regard*, and *empathic understanding* (Landreth, 2012). *Congruence* describes the therapist's ability to be herself or himself in the therapeutic relationship, and "is a combination of the therapist's self-awareness, acceptance of such awareness, and appropriate expression of awareness to the child" (Ray & Landreth, 2016, p. 6). *Unconditional positive regard* is the warm, non-judgmental acceptance of all of the child's experience; it also includes the therapist's belief in the child's capacity for growth and change. *Empathic understanding* is the process of entering the child's world with curiosity and respect. For change to occur, the child must be able to perceive the therapist's unconditional positive regard and empathic understanding (Ray & Landreth, 2015).

Therapists implementing CCPT are non-directive, allowing the child to lead the play session (Ray & Landreth, 2015). They respond to the child's play by tracking behavior (e.g., "You're filling up the bucket."), reflecting content and feelings (e.g., "Your sister took your book." "You're angry."), returning responsibility to the child (e.g., "You can decide what to do."), facilitating creativity (e.g., "You can make that be whatever you want."), providing encouragement and building self-esteem (e.g., "You're working really hard."), facilitating relationship (e.g., "You want me to know that you care about me."), and setting therapeutic limits (e.g., "I'm not for biting."). CCPT uses a three-step model for limit setting: acknowledge the feeling, communicate the limit, and target an alternative (e.g., "You're mad at me, but I'm not for hitting. You can hit the bear."). Therapist responses in CCPT do not include asking questions, as questions "place the child in the adult's world of verbal expression," and show a lack of understanding of the child's world (Ray & Landreth, 2015, p. 9).

**Setting.** CCPT has been implemented in clinics, community agencies, schools, and domestic violence and homeless shelters.

**Resources.** Toys are the medium through which children in play therapy express themselves; the toys selected for the CCPT playroom therefore have an effect on the child's expression and interaction with the therapist (Landreth, 2012). A playroom should have three categories of toys. Real-life toys directly represent the real world; they include doll families and dollhouses, puppets, cars, airplanes, and play money. Aggressive release toys allow the child to release emotions that may not be acceptable elsewhere, and include toy soldiers, rubber knives, and inflatable punching toys, as well as items that the child can physically break or tear apart, such as tongue depressors and egg cartons. Creative expression toys allow the child to express creativity, and include paints, crayons, paper, modeling clay, and musical instruments (Landreth, 2012). In a clinic or community agency setting, a playroom may include larger toys, such as a kitchen, an easel, or a sand tray. Therapists who work in multiple locations may create a mobile playroom of toys that fit in a tote bag or rolling suitcase.

**Provider requirements.** Training in CCPT requires licensure as a mental health provider ("Child-Centered Play Therapy Certification", n.d.). Basic CCPT training is 12 hours over two days; Practice and Applications training is 18 hours over three days. Therapists complete two supervised cases before practicing independently. CCPT manuals are available online ("Center for Play Therapy Publications", n.d.).

**Evidence base for intervention.** CCPT is listed in both the CEBC and NREPP registries. The CEBC lists CCPT in the category of anxiety treatment and disruptive behavior treatment, and rates its scientific reliability as 3 and its relevance for child welfare as medium ("Child-Centered Play Therapy [CCPT]", 2017). NREPP reviewed CCPT in 2017, and listed it as promising for general functioning and well-being, anxiety disorders and symptoms, and disruptive behavior disorders and symptoms ("Child-Centered Play Therapy", 2017).

CCPT has been implemented with children who present with symptoms of trauma, anxiety, and aggression, with attention problems or disruptive classroom behavior, as well as with children who present with general internalizing and externalizing problems. CCPT has been implemented with children and sibling pairs living in domestic violence shelters (Kot, Landreth, & Giordano, 1998; Tyndall-Lind, Landreth, & Giordano, 2001), and with homeless children (Baggerly, 2004).

With the 2009 passage of the HEARTH Act, the federal definition of homelessness now includes families living in domestic violence shelters. Including shelters designated for survivors of domestic abuse is overdue, because domestic violence is frequently cited as a precipitating event that leads women and their children to emergency homeless shelters. Interventions that are effective in treating child witnesses of domestic violence are also likely to be effective in treating other homeless children.

Intensive individual CCPT has been found to be effective in treating child witnesses of interparental violence who were in domestic violence shelters. Kot, Landreth, and Giordano (1998) studied an intensive 12-session CCPT treatment for 40 children, ages 4–10, who were living in three domestic violence shelters. During the study, 18 children left the shelter; 22 children completed the study. Of the children in the intervention group ( $n = 11$ ), 46% were White, 27% were African American, and 27% were Hispanic. Six were female and five male; their mean age was 6.9 years. In the control group ( $n = 11$ ) 15% of the children were White, 15% were Hispanic, and 70% were African American. Seven were female, and four male; their mean age was 5.9 years.

Over a period of 12 days to three weeks, children in the intervention group received 12 45-minute sessions of CCPT (Kot et al., 1998). Children in the control group received two

sessions of CCPT two weeks apart, corresponding to the intervention group's first and last sessions. Children in both the intervention and control groups participated in the shelters' regular psycho-education and recreational groups. To avoid any feeling of unequal treatment, Kot et al. (1998) selected the control group after the children in the intervention group had completed the intervention and moved out of the shelters.

Participants were assessed pre- and post-intervention (Kot et al., 1998). Mothers completed the CBCL (discussed in Chapter III), and children completed the Joseph Preschool and Primary Self Concept Scale (JSCS). The JSCS is a 15-item instrument that measures the self-concept of children ages 3 years 6 months to 9 years 11 months. Self-esteem is assessed based on children's identifying which of a pair of pictures of opposite situations (e.g., child alone in a corner or group of children playing together) is most like them. The domains the JSCS measures are significance (i.e., the extent to which children value themselves), competence (i.e., children's beliefs about their capacity for achievement and meeting others' requirements), and general contentment (i.e., children's satisfaction with their current life circumstances).

Following CCPT treatment, children in the intervention group showed, on average, significant improvements in self-concept as measured by the JSCS ( $p < .001$ ) (Kot et al., 1998). Mothers noticed increased confidence and decreased self-blame in their children. The play therapists noted that the children's play became more self-assured and less fearful. Further, at the completion of the study, mothers of intervention group children reported fewer child behavior problems on the CBCL; by contrast, control group mothers reported more problems (Kot et al., 1998). In the intervention group, Kot et al. found significant reductions in CBCL total problems ( $p < .01$ ) and externalizing behaviors ( $p < .05$ ). Kot et al. found the mothers' reports of decreased externalizing behaviors notable because mothers who have experienced domestic violence tend

to over-report behavior problems in their children. While mean reductions in internalizing behaviors in the intervention group approached but did not reach significance ( $p = .06$ ), intervention group mothers reported fewer concerns about child withdrawal, somatic complaints, anxiety, and depression post-treatment. Additionally, mothers verbally reported to the play therapists that their children's nightmares had stopped after they began CCPT. Kot et al. did not report on control group mothers' experiences of their children.

Working in the same domestic violence shelter setting as Kot et al. (1998), Tyndall-Lind, Landreth, and Giordano (2001) found that intensive CCPT with sibling pairs was effective in reducing children's behavior problems and increasing self-esteem. Tyndall et al. used the same control group as Kot et al., and used Kot et al.'s intervention group of children who had received individual CCPT as a comparison group to examine differences in the effectiveness of individual and sibling CPPT. Tyndall-Lind et al.'s (2001) sample was five sibling pairs, including six girls and four boys. The children's ages ranged from 4 to 9, with a mean age of 6.2 years; siblings were no more than three years apart in age. In this sample, 60% of the children were White, 20% were Hispanic, and 20% were Black.

Children in the intervention group showed significant improvements, on average, in self-concept as measured by the JSCS ( $p < .001$ ) (Tyndall-Lind et al., 2001). Tyndall-Lind et al. referred to self-concept as "a function of the caretakers' expectations and beliefs that become internalized as self-worth," and stated that, "in terms of this definition, children who participated in sibling group play therapy, within a nurturing context, had the experience of being valued, respected, and honored and thus changed their self-perception" (p. 69).

Children in the sibling CCPT group also showed reductions in behavior problems, on average, as measured by the CBCL, compared to the control group (Tyndall-Lind et al., 2001).

The sibling CCPT group scored significantly lower on average ( $p < .01$ ) than the control group on the total and externalizing scales. Additionally, the sibling CCPT group showed a significant decrease ( $p < .01$ ) in aggressive behaviors, on average, from pre-test to post-test. Tyndall-Lind et al. (2001) noted that "the expression of aggression in fantasy tends to decrease tension in traumatized children. Children in the control group showed an increase in aggressive behavior that may be attributed to an absence of effective outlets for tension" (p. 70). Children in the sibling CCPT group also showed a decrease in internalizing behavior problems, on average, as compared to the control group.

Tyndall-Lind et al.'s (2001) findings showed no significant differences in outcomes between the sibling CCPT group and the individual CCPT group from Kot et al.'s (1998) study. However, Tyndall-Lind et al. maintained that sibling CCPT provided additional benefits to the sibling group that were not available in individual CCPT:

During intensive sibling group play therapy, children experienced a new family dynamic compared to children in intensive individual play therapy who only had access to the positive relationship between themselves and the therapist. Intensive sibling group play therapy decreased feelings of isolation and secrecy established in the home environment and provided children with an open forum to express what occurred within the family. (p. 74)

Both Kot et al.'s (1998) and Tyndall-Lind et al.'s (2001) studies had limitations. Sample sizes in the Kot et al. study were small, particularly because 18 of the original 40 participants moved out of the shelters during the research. Families typically stayed at the shelters from a minimum of several days to a maximum of four to five weeks; this 45% attrition rate reflected the limited time that some families spent in the shelter. Also, in both studies, the time between

the beginning and end of the intervention and the control condition differed; the intervention conditions ranged from 12 days to three weeks, while the control condition had two weeks between the beginning and end assessments. Neither Kot et al. nor Tyndall et al. specified the number of days for their intervention conditions; if the durations were greater than two weeks, the elapsed time might have become a point to consider in the effects. Because both Kot et al. and Tyndall et al. organized their studies so that the intervention and control groups did not reside in the shelters at the same time, assignment to the intervention and control groups was by convenience, rather than randomized. Finally, approximately half of children in the individual CPPT and sibling CPPT groups were White (46% and 60% respectively), while children in the control group were predominantly (70%) Black; these differences in the racial/ethnic characteristics of the samples may have affected the findings.

Studying children in a homeless shelter, Baggerly (2004) found CCPT to be effective in improving self-concept, anxiety, and some aspects of depression. Participants were referred by either a parent or a teacher at the shelter's school, based on emotional or behavioral concerns. During a two-year period, 52 children were recruited for the study. However, while 42 children began play therapy, only 25 received the planned 9 to 12 sessions of CCPT; because families moved out of the shelter, participants' dropout rate was 48%. The age of the 42 children who began play therapy ranged from 5 to 11 years, with a mean age of 8 years. Thirty-one were (73.8%) boys, and 11 (26.2%) were girls. Of the 42 children, 71.4% were Black, 11.9% were Hispanic, and 16.7% were White.

Baggerly (2004) had planned to include a control group in the study. However, she reported that "parents and teachers were desperate to receive play therapy services for children before they moved from the homeless shelter" (p. 37). Due to the high dropout rate and ethical



considerations, Baggerly decided to forego the control group and provide services for all study participants.

Using the JSCS, the Children's Depression Inventory (CDI), and either the Child Anxiety Scale (CAS) or the Revised Children's Manifest Anxiety Scale (RCMAS), Baggerly (2004) assessed the children for self-concept, depression, and anxiety both pre- and post-intervention. Some children were not assessed with some instruments because the children were not within the age range for which the instrument was designed, and because the study's funding was insufficient to purchase two of the intended instruments until the second year. Pre-test assessments showed that over half the children rated low in self-concept, with 35% considered to be at high risk. Thirty-five percent of children had clinical levels of depression and/or anxiety, with depression found in 17% of children, and anxiety in 19%.

Children received 9 to 12 30-minute group CCPT sessions once or twice a week (Baggerly, 2004). The groups were limited to two children because the shelter's playroom was small, and the children's needs were high. Due to the limited budget, the play therapists used a small assortment of representational, aggressive release, and creative play materials that they brought in play therapy tote bags.

Post-intervention, Baggerly (2004) reported that the participants showed significant improvement in several areas. Results indicated significant improvements in self-concept, on average ( $p > .05$ ). While some aspects of children's depression (e.g., negative mood [ $p > .05$ ] and negative esteem [ $p = .09$ ]) showed significant improvement, changes in overall mean depression scores were not significant. Significant improvements were found in mean scores for total anxiety ( $p > .05$ ) and physiological anxiety ( $p > .05$ ), but not on other subscales (e.g., worry and social concern).

Suprisingly, Baggerly (2004) reported  $p$  values  $> .05$  and  $= .09$  as significant. Typically, only  $p$  values  $< .05$  have been considered significant in social science research (Schumm, Pratt, Hartenstein, Jenkins, & Johnson, 2013). However, in discussing the use of higher  $p$  values, Schumm et al. (2013) noted that “from 2005 to 2009, the percentage of articles reporting results for  $p < .10$  increased from 9.2% to 13.1%, contradicting any possible notion that the use of  $p < .10$  was on a decline as ‘scholarship’ was improving” (p. 4). They also noted that some, but not all, researchers who reported higher  $p$  values had smaller samples. While Baggerly did not discuss her use of these higher  $p$  values, they apparently were acceptable to the peer-reviewed journal that published this study.

Baggerly’s (2004) study had limitations related to funding, sampling, and ethical considerations. In addition to limiting the assessment instruments available for the study, the lack of funding may also have limited the time frame for recruiting the sample and conducting the intervention. When studying the highly mobile population of homeless shelter residents, researchers may need to obtain funding for an extended period of data collection to increase participant numbers and the power of the study’s findings. Baggerly’s ethical stance on providing services to all of the referred children is laudable. In the absence of a control group of children referred for services, Baggerly might have developed a control group of children living in the shelter who were not referred for services. Identifying differences between the CCPT group and the control group would have allowed for comparing their baseline functioning and post-intervention functioning, as well as measuring any changes in the non-referred children due to time in the shelter.

***Child-Centered Play Therapy with homeless families.*** In office settings, play therapists typically conduct CCPT over 16–20 weeks with weekly sessions; schools settings typically see

two sessions weekly over eight weeks (Ray & Landreth, 2015). Either of these approaches might be feasible for families living in transitional housing, in which the average stay is 11–15 months (Gubits et al., 2016) and the maximum residency is two years. With families staying in homeless shelters for an average of seven weeks (Solari et al., 2016), either of the intensive 12-session models of individual or sibling CCPT as described in Kot et al. (1998) and Tydall-Lind et al. (2001) or the twice-weekly model as Baggerly (2004) used would be feasible for many.

CCPT does not involve the caregiver directly in the treatment. Treatment of a young child with his or her mother is preferable, due to the importance of the primary attachment relationship to the child's development. However, some young children experiencing homelessness may have caregivers who are unwilling to participate in treatment themselves, although they will allow it for their children. Other children may have caregivers who are unavailable emotionally or unable to fully engage in treatment due to their personal histories and the stresses they are facing. For these children, CCPT would be a good option. The only attrition reported in the studies of CCPT conducted in domestic violence shelters and homeless shelters occurred when families moved out of the shelters. While nearly half of the participants did not complete CCPT, the attrition rates for other evidence-based intervention models included in this literature review were often as high or higher in studies with low-income, disadvantaged populations. CCPT studies may have had lower attrition rates than studies of other models because treatment involved the child only, or because therapists provided treatment at the shelters.

For young children who may have experienced emotional neglect, lack of attunement, or intrusiveness from their caregivers, the CCPT therapist's non-directive, attuned, empathic approach may be a new experience. The therapist's responses, such as tracking behavior,

reflecting feelings, and building self-esteem, are similar to the behavior of an attuned caregiver toward a young child. The idea that self-concept is “a function of the caretakers' expectations and beliefs that become internalized as self-worth” (Tyndall-Lind et al., 2001, p. 69) seems analogous to the internal working model of the self. That a child's self-concept changes during CCPT may indicate that the attachment relationship that the child forms with the therapist leads to shifts in the part of the child’s internal working models that relates to self. Pre- and post-test assessments of mental representations of other people might show changes in other aspects of the child’s internal working models.

While formal training and certification in CCPT require graduate education and licensure as a mental health provider, non-clinical shelter staff could be trained in some CCPT skills. Carter (2016) advocated for training shelter providers in core CCPT concepts: following the child’s lead, communicating empathy, reflecting content and feeling, and setting appropriate limits using the acknowledge-communicate-target method. Use of these skills even in non-play situations can help a child to feel seen and heard, and perhaps to feel less distressed and better regulated in a shelter setting.

**Child-Parent Psychotherapy.** Child-Parent Psychotherapy (CPP) is a manualized, relationship-based intervention for infants and children under 6 years old who have emotional or behavioral disturbances as the result of traumatic experiences, relational disruptions, adverse environmental conditions, or psychosocial risk factors (Lieberman & Van Horn, 2011). CPP is typically implemented in one year of weekly, one-hour sessions. CPP’s theoretical base is psychodynamic, with a focus on attachment. CPP was developed in the 1980s as an outgrowth of social worker and psychoanalyst Selma Fraiberg’s work in infant mental health and psychotherapy.

***Intervention goals.*** The primary goal of CPP is to return a neglected, abused, or traumatized child to a normal developmental path (Lieberman & Van Horn, 2011). CPP uses the parent-child relationship as the primary target of intervention, because “loving parental care has unmatched transformational powers in restoring the child’s developmental momentum in risk situations. The parents constitute the primary agents of the young child’s emotional well-being even in the presence of environmental stresses and constitutional child vulnerabilities” (Lieberman & Van Horn, 2011, p. 5).

***Intervention process.*** The beginning phase of CPP is highly structured. The therapist meets alone with the parent for an average of five sessions (Diaz & Lieberman, 2010; Van Horn & Reyes, 2016). CPP therapists see these sessions as crucial to building a strong alliance between therapist and parent. The therapist also uses the first sessions to assess both the child and the parent clinically. The therapist and parent discuss the parent's concerns about the child, details of the trauma the child has experienced (e.g., maltreatment, the death of someone close, a severe accident, sexual abuse, exposure to domestic violence), and how the parent understands the trauma and its effects on the child. The therapist also assesses the parent’s relational and trauma history and the capacity to regulate his or her affect when discussing trauma material. The therapist may use standardized instruments to assess the child’s behavioral and developmental functioning and trauma symptoms and the parent’s trauma history. The therapist provides psycho-education about the effects of trauma on children, making connections between the child’s trauma history and his or her current symptoms.

During the second part of the assessment, the therapist meets with the parent and child together (Diaz & Lieberman, 2010). The therapist observes a play session that includes free play, structured activities, and a brief separation-reunion to assess the quality of the dyadic

relationship. The therapist discusses with the parent the ways that children may use play to express and process trauma.

Following assessment, the therapist and parent meet for feedback and planning (Diaz & Lieberman, 2010). The therapist reviews the results from any screening instruments with the parent, and together they decide on treatment goals for the child. The therapist and parent select a collection of age-appropriate toys to provide to the child, some of which may evoke the child's traumatic experience, along with others to help the child and caregiver regulate. Finally, the therapist and parent discuss how to introduce the treatment to the child. CPP therapists encourage parents to tell children, using age-appropriate language, that the therapy is intended to help the child with his or her feelings about the stressful or traumatic experience. The therapist repeats the explanation in the first joint session, and as needed throughout treatment, so that the child, parent, and therapist maintain their awareness of the reason that the child is in therapy.

Van Horn and Reyes (2016) gave this example:

For example, the child may be told, “You saw your daddy hit your mom and make her face bleed. You cried and told him to stop. That is so scary for kids, and your mom is worried that you are still scared about what you saw. She says that you have bad dreams and that sometimes you get so mad that you hit other people. My job is to help your mom help you understand what happened and help you feel better.” (p. 65)

As in Van Horn and Reyes’ illustration, the therapist includes any emotional and behavioral symptoms the child is experiencing (e.g., having bad dreams, hitting people) in the explanation.

During the treatment phase, in which the therapist, mother, and child meet together, the child sets the pace of treatment (Van Horn & Reyes, 2016). The therapist follows the child’s lead in play, and encourages the parent to do so as well. The child is allowed to bring trauma material

into his play on his own time; this may occur in the first session, or may follow an initial period of play related to normative developmental processes.

In implementing CPP, the therapist uses multiple intervention modalities including supporting developmental momentum, providing unstructured reflective developmental guidance, modeling appropriate protective behavior, making insight-oriented interpretations, addressing traumatic reminders, providing emotional support, and attending to the realities of the clients' lives (Lieberman & Van Horn, 2011).

Since the goal in CPP is to return the child to healthy, age-appropriate functioning, the therapist supports interactions between parent and child that promote the child's developmental momentum (Lieberman & Van Horn, 2011). These include play, putting feelings into words, and protective and affectionate physical contact. Play is young children's primary mode of symbolic expression, through which they communicate memories, fears, wishes, or fantasies for which they have no words. Children may use play to recreate a distressing experience and create a different ending, or they may avoid the anxiety of the experience by choosing a different play theme. The CPP therapist encourages the parent and child to play together; during sessions, the therapist translates the language of the child's symbolic play so that the parent can understand its meaning. Learning to put feelings into words helps children and their parents understand and manage emotions. Strong feelings are always experienced in the body, and translating physical sensations into words is a key component in developing affect regulation. Working with young children, the therapist will most often read the child's non-verbal cues and suggest what the child might be feeling. The verbal expression of feelings helps the parent and child connect with each other's emotions, and builds intimacy in their relationship. These experiences of love, security, and intimacy can be shared and enhanced through physical contact, since emotions are

embodied. The CPP therapist encourages appropriate affectionate and protective touch between parent and child, as touch enhances the child's sense of protection and leads to pleasurable, loving bodily experiences.

The therapist's unstructured reflective developmental guidance provides information to the caregiver about age-appropriate child development, feelings, and needs as the child experiences them in sessions (Lieberman & Van Horn, 2011). The guidance is unstructured in that it responds to what comes up in sessions rather than following a set curriculum; it is reflective in that it encourages the mother to think about and empathize with her child's experience. When a child has experienced stressful or traumatic events, developmental guidance may also include psycho-education about typical emotional and behavioral responses to such events. In addition to helping the mother to understand her child better, developmental guidance can be reassuring to a child who learns that other children feel the same way that he or she does.

The therapist models appropriate protective behavior by taking action to stop a child from self-harming, endangering himself or herself, or from hurting others (Lieberman & Van Horn, 2011). Traumatized parents and children often are unable to appraise safety and danger realistically, either minimizing hazardous situations or misperceiving threat in situations that have little actual risk. Furthermore, trauma damages children's belief that their parent will be able to protect them. The therapist's protective actions model accurate appraisals of danger for both the parents and children, and help the children to believe that their parent can learn to protect them.

The therapist's insight-oriented interpretations help to identify the unconscious or symbolic meanings of behavior, leading to new understandings of self or others (Lieberman & Van Horn, 2011). The therapist may point out how experiences and beliefs from the parent's past



are unconsciously being repeated in the parent's relationship with the child in the present.

Bringing the repetition to awareness allows the parent to revise inaccurate perceptions of the child, and to learn new, more appropriate parenting practices. The therapist's interpretations may help the child to understand that she or he is not responsible for stressful events, relieving her or him of self-blame and false beliefs about reality.

Traumatic reminders take many forms, including traumatic play, reenactment of trauma, traumatic dreams, and physiological and emotional dysregulation (Lieberman & Van Horn, 2011). Some events, such as the death of a family member or domestic violence that the child has witnessed, traumatize both the child and the parent. Witnessing a traumatic event that the child has experienced, such as abuse by the other parent or a near-fatal accident, may also lead to vicarious trauma in the parent. The CPP therapist helps the child and parent to make sense of the child's sometimes fragmented memories and feelings about the trauma, and to weave together a coherent verbal narrative that describes the child's experience.

The therapist's emotional availability to the client is a fundamental aspect of effective therapy (Lieberman & Van Horn, 2011). Emotional support includes holding out hope that the child and parent can achieve the treatment goals, noting signs of progress, sharing pleasure and pride in accomplishments, and promoting effective coping strategies. Emotional support is essential for mothers whose self-worth has suffered due to difficulties and expectations related to motherhood or to experiences of poverty, discrimination, and powerlessness. The goal of CPP is developing a caring, considerate relationship between parent and child; the therapist models that relational stance in her interactions with the parent and the child.

Attending to the reality of clients' lives may involve crisis intervention and case management, as well as concrete assistance with problems of daily living (Lieberman & Van

Horn, 2011). These modalities are often the first interventions for a therapist who is working with families dealing with significant socioeconomic, environmental, and interpersonal stressors. Providing these practical interventions may take more time than the allotted one-hour weekly session, but “this schedule becomes irrelevant at times of crisis or immediate need” (Lieberman & Van Horn, 2011, p. 91). One ramification of this approach is that the therapist’s caseload cannot be so high that she has no flexibility to respond to emergent problems.

Termination of CCP is planned when the therapist and parent agree that treatment goals have been met (Diaz & Lieberman, 2010). In many cases, this occurs when the parent feels prepared to continue helping the child process the trauma and to proceed with healing the parent-child relationship without further help from the therapist. The parent understands the impact of trauma, has developed perspective on the traumatic experience, can keep herself and the child safe, and is more effective in responding to the child's needs. Since separations and endings may be traumatic reminders for the parent and child, the CPP therapist aims to make termination a corrective emotional experience. The termination phase usually occurs over two months, and includes summarizing themes of the treatment, developing plans for addressing trauma reminders that may arise, and encouraging hope for the future.

***Setting.*** CPP was initially developed as a home-visiting intervention. It is now conducted in both home and office settings.

***Resources.*** CPP uses a carefully selected, age-appropriate set of toys for engaging the child in play (Lieberman & Van Horn, 2011). Some toys may be chosen to evoke a child’s traumatic experience (e.g., doctor and nurse figures or medical equipment toys for a child traumatized by a medical procedure, or a police car for a child who witnessed an arrest following interpersonal violence), and others provide mother and child the opportunity to co-regulate.

***Provider requirements.*** Training in CPP requires a master's or doctoral degree and licensure as a mental health provider. Initial training is three days, followed by three quarterly two-day workshops ("Child-Parent Psychotherapy Training for Agencies", n.d.). Additionally, training involves bi-monthly distance case consultation of ongoing treatment cases for a year. Three treatment manuals for CPP are available from online booksellers (e.g., Amazon.com, powells.com).

***Evidence base for intervention.*** Both the CEBC and NREPP list CPP. The CEBC lists CPP as an intervention in the categories of infant and toddler mental health, and trauma treatment – client-level interventions (child and adolescent). It rates CPP's scientific reliability as 2 and its relevance for child welfare as high ("Child-Parent Psychotherapy [CPP]", 2015). NREPP lists CPP under its pre-2015 criteria, and includes outcomes for child PTSD symptoms, child behavior problems, child's representational models, attachment security, maternal PTSD symptoms, and maternal mental health symptoms other than PTSD symptoms ("Intervention Summary Child-Parent Psychotherapy", 2010).

CPP has been studied in various clinical populations, including toddlers of mothers with major depressive disorder (Toth, Rogosch, Manly, & Cicchetti, 2006), maltreated infants (Cicchetti et al., 2006; Stronach, Toth, Rogosch, and Cicchetti, 2013), and preschool children exposed to domestic violence.

Toth et al. (2006) found that CPP was effective in fostering attachment security in the young children of mothers with major depressive disorder. Participants were 198 mother-child dyads with mothers who had experienced a major depressive disorder (MDD) at some time since their child's birth, and a comparison sample of 68 non-depressed mothers and their children. To minimize possible co-occurring risk factors, Toth et al. (2006) recruited participants who were

not low-income; the sample they obtained was predominantly White. The children's mean age was 20.34 months.

Depressed mother-child dyads were randomly assigned to the intervention group (CPP) or the MDD comparison group (MDC); a non-depressed control group (NDC) was also established (Toth et al., 2006). Mother-child dyads in the CPP group participated in CPP for an average of 45 sessions in 58 weeks. Mothers in the MDC and NDC groups were allowed to seek mental health treatment during the study. During the period of the study, 46.7% of the MDC group and 44.2% of the NDC group mothers received some mental health intervention.

Some participants were lost to attrition (Toth et al., 2006). Twelve mothers assigned to CPP group either failed to engage in the intervention or dropped out of treatment early. Twenty mothers either discontinued participation or moved away from the area before follow-up assessment. Overall attrition was 16%. No differences were found between those who did and did not complete the study.

Toth et al. (2006) measured attachment security for all participant dyads both pre- and post-intervention using the Strange Situation. As hypothesized, they found that maternal depression was related to insecure attachment in children: Pre-intervention rates of insecure and disorganized attachment were higher in both groups with depressed mothers than in the group of non-depressed mothers. Pre-intervention, significantly fewer children in both the CPP group and the MDC group were classified as secure than children in the non-depressed control group ( $p < .001$ ). Significantly more children in the CPP group ( $p < .01$ ) and the MDC group ( $p < .02$ ) had disorganized attachments than children in the NDC group. Post-intervention, Toth et al. found no significant changes in the attachment classifications of the MDC or NDC control groups. However, attachment classifications in the CPP group had changed substantially: More children

in the CPP group had secure attachments, and fewer had disorganized attachments, than children in the NDC group. Secure attachment in the CPP group was significantly greater than in the MDC group ( $p < .001$ ) and in the NDC group ( $p < .04$ ). Disorganized attachment in the CPP group was significantly lower than in the MDC group ( $p < .001$ ), although not significantly different from the NDC group.

Toth et al.'s (2006) study had limitations related to generalizability. The researchers chose to recruit middle-class participants; the resulting sample was 93% White, and 88% of mothers were married. While they intended to minimize confounding risk factors related to poverty, their choice of sample limits the generalizability of their results to single mothers from low-income, racial and ethnic minority populations. Given that low-income and homeless mothers have higher rates of depression than the general population of women, and that low-income and homeless children have lower rates of secure attachment than middle-class children, this sampling decision omitted the population with the highest needs.

CPP has been effective in reorganizing attachment in mother-child dyads from maltreating families (Cicchetti et al., 2006). Participants were 137 mother-infant dyads in maltreating families recruited through CPS, and 52 non-maltreating low-income families recruited through the Temporary Assistance to Needy Families (TANF) rolls. Just over 74% of mothers in the sample were of a minority race or ethnicity. The children's mean age was 13.3 months; 101 were girls and 88 boys. Cicchetti et al. (2006) randomly assigned the mother-child dyads from maltreating families to CPP, a psycho-educational parenting intervention (PPI), or a community standards control group (CS). The low-income, non-maltreating families formed a second control group (NC).

Both the CPP and PPI groups received in-home sessions for a year (Cicchetti et al., 2006). The CPP group mother-child dyads had CPP sessions. Unlike CPP, the PPI sessions focused only on the mothers. Mothers in this group had weekly in-home sessions of PPI, which provided didactic information about child development and parenting skills, and used cognitive and behavioral techniques to help mothers with parenting, relaxation strategies, and social support resources. Although the therapists scheduled weekly sessions for both CPP and PPI groups, an average of 22 sessions were conducted in the CPP group and 25 sessions in the PPI group due to missed appointments and cancellations.

Cicchetti et al. (2006) found that many mothers did not complete the study. Forty percent of mothers assigned to CPP and 51% of those assigned to PPI were unwilling to engage in treatment. Of those who completed CPP and PPI, 21% did not participate in the follow-up assessment.

Pre- and post-intervention, Cicchetti et al. (2006) conducted assessments of the mother and the mother-child relationship. They used the Strange Situation to assess attachment at baseline and post-intervention. The mothers were also assessed for trauma history, childhood and adult attachment experiences and states of mind, parenting stress, and social supports. At baseline, mothers in the maltreatment groups reported significantly more adversity and relational difficulty in their lives on average compared to the non-maltreatment group mothers (Cicchetti et al., 2006). They had experienced higher levels of abuse and neglect in their childhoods. They reported more insecure relationships with their mothers, expressed more anger at their mothers, and were more dismissive of attachment relationships. They reported more maladaptive parenting attitudes, greater parenting stress, lower family support, and were observed to have lower maternal sensitivity than the non-maltreatment group. At baseline, the child attachment

classification distributions of the three maltreatment groups (CPP, PPI, and CD) differed significantly from that of the NC control group. Children in the maltreatment groups showed higher levels of disorganized attachment than those in the NC group ( $p < .001$  in all comparisons). While secure attachment was lower than middle-class norms in the NC group, it was almost non-existent in the three maltreatment groups.

Post-intervention, the CPP and PPI groups showed substantial increases in secure attachment and decreases in disorganized attachment (Cicchetti et al., 2006). Secure attachment did not increase in the CS and NC groups. Rates of secure attachment in the CPP and PPI groups were similar to those in the NC group, but were significantly higher than in the CS group ( $p < .001$  for all comparisons). Rates of disorganized attachment in the CPP and PPI groups also were similar to the NC group, but were significantly lower than in the CS group ( $p < .001$  for all comparisons). Post-intervention, the effect of the CPP and PPI interventions on attachment security appeared equally effective in fostering secure attachment.

Following up on Cicchetti et al. (2006), Stronach et al. (2013) examined the persistence of changes in children's attachment classifications 12 months after the CPP and PPI interventions. The attrition rate for the follow-up was 21.7%, with 145 of the original study's participants completing assessments that included the Strange Situation. Comparing the three maltreatment groups, Stronach et al. found that children in the CPP group still had higher rates of secure attachment and lower rates of disorganized attachment than did children in the CS group; however, children in the PPI group no longer showed gains in attachment security. As Cicchetti et al. (2006) found post-intervention, the rate of disorganized attachment in the CPP group was similar to the NC group. However, at the 12-month follow-up, the PPI group's rate of disorganization was significantly higher than that of the NC group, and similar to the CS group.

Changes in attachment security in maltreated children were maintained 12 months after completing CPP, but not PPI. Stronach et al. (2013) noted that, “although effective in the short term, parenting interventions alone may not be effective in maintaining secure attachment in children over time” (p. 919).

The design of Cicchetti et al. (2006) and Stronach et al.’s (2013) studies had strengths related to sampling and controls. Providing an intervention to the second maltreating (PPI) group that focused on the parent, rather than targeting the parent-child relationship, afforded the opportunity to compare the effectiveness of two common approaches to treatment. Including a control group of non-maltreating low-income families (NC) provided the opportunity to learn whether the effect of CPP on the attachment distributions of that subsample resembled the attachment distributions of the NC group. Cicchetti et al. (2006) indicated that their findings on the effects of the PPI parenting intervention concerning increased attachment security and decreased disorganization were unexpected; Stronach et al.’s (2013) 12-month follow-up provided valuable findings regarding the persistence of changes in attachment security and organization following CPP, but not PPI.

***Child-Parent Psychotherapy with homeless families.*** CPP is described as a 52-session intervention; however, Cicchetti et al. (2006) reported significant increases in attachment security among their intervention sample with an average of 22 sessions. For many families in emergency shelters, where the average stay is seven weeks (Solari et al., 2016), completing even a shortened course of CPP would not be feasible. For families living in transitional housing, with a maximum 2-year residency and an average stay of 11-15 months (Gubits et al., 2016), the time frame of CPP would be feasible.



Treatment of a young child with his or her mother is preferable, due to the importance of the primary attachment relationship to the child's development. However, at times, particularly during a longer treatment, some mothers may have difficulty fully engaging in treatment with their children due to their personal histories and the difficulties they or their children are experiencing. The literature on CPP recognized this possibility, and indicated that CPP may be adapted to provide individual sessions for the mother and the child until both are able to reengage more comfortably and productively (Lieberman & Van Horn, 2011).

One aspect of CPP that seems particularly appropriate for working with homeless families is its focus on attending to the realities of clients' lives. As well as doing clinical work, CPP therapists are expected to provide crisis intervention and case management as needed. While most transitional housing programs provide some form of case management services, the CPP therapist's willingness to get involved in the complexities of homeless clients' lives beyond the time frame of sessions is likely to strengthen the relationship with the clients.

**Parent-Child Interaction Therapy.** Parent-Child Interaction Therapy (PCIT) is a manualized intervention developed in 1974 for children 2 to 7 years of age with disruptive or externalizing behavior problems (Urquiza & Timmer, 2014). PCIT is typically implemented in 14–20 one-hour sessions, which may be conducted once or twice weekly. The theoretical underpinnings of PCIT are social learning and attachment theories. While PCIT is a behavioral intervention, its training organization recognizes the importance of attachment security, which it describes as fundamental to a parent's ability to manage a child's behavior: "PCIT posits that a strong, secure attachment relationship is a necessary foundation for establishing effective limit setting and consistency in discipline, which leads to improved mental health for both parent and child" (PCIT International, n.d., para. 5).

***Intervention goals.*** The goals of PCIT are to enhance the quality of the parent-child relationship, improve parenting skills, and decrease child behavioral problems (Urquiza & Timmer, 2014). PCIT has two phases of treatment: Child-Directed Interaction (CDI) and Parent-Directed Interaction (PDI). The CDI phase focuses on improving the parent-child relationship; the PDI phase focuses on improving the child's behavior and compliance. Both phases of treatment focus on developing a specific set of parenting skills.

***Intervention process.*** Each phase of PCIT begins with an hour of didactic training for parents on the goals and methods of the phase (Urquiza & Timmer, 2014). Following the teaching session, parents and children participate in play sessions during which therapists coach the parents on developing that phase's skills. For the first five minutes of each session, therapists code the parents' verbalizations to assess parents' progress in skill acquisition.

In the CDI phase, typically 7–10 sessions, the therapist coaches the parent in following the child's lead in play sessions (Urquiza & Timmer, 2014). The acronym *PRIDE* represents the skills the parent learns: Praise, Reflection, Imitation, Description, and Enjoyment. Parents are encouraged to praise the child's positive behavior, to reflect his or her appropriate verbalizations, to imitate the child's play, to describe the child's actions, and to show enjoyment or enthusiasm with the child. In PCIT, these encouraged verbalizations are called *Do Skills*. Urquiza and Timmer (2014) provided an example of CDI coaching:

Therapist: Describe what Robert is doing with his hands.

Robert: (plays with blue Legos)

Parent: You put all of the blue Legos on the table.

Therapist: That was a great behavioral description!

Child: Yes, I'm going to make a big blue tower.

Parent: Oh... you're going to make a big blue tower

Coach: You got it! That was a perfect reflection of what Robert said. He knows you are paying attention to what he is doing. When you give him praise and attention for his good behavior, he will do more of that behavior.

Child: And I'm going to make a red barn too!

Therapist: You make a red barn too, Mom.

Parent: That's a great idea! I'm going to make a red barn just like you.

Therapist: Great imitating! He really knows you're paying attention when you imitate his play.

Child: Okay, you build yours right here, and the cow will go in it.

Therapist: Robert is playing very gently with the toys today. And so creative!

Parent: Robert, you are so creative with these Legos. You know just what to do!

Child: Yeah!

Therapist: Nice labeled praise, Mom. (p. 126)

Parents are also coached to avoid asking questions, giving commands, or criticizing the child. In PCIT, these discouraged verbalizations are called *Don't Skills*. Parents also learn to actively ignore inappropriate behavior by not responding either verbally or physically, unless the behavior is destructive or dangerous. To complete the CDI phase, parents must be able to give ten behavior descriptions (e.g., "You put all of the blue Legos on the table."), ten reflections (i.e., repeating the child's words), ten labeled praises (i.e., praises for specific behaviors, such as "Thank you for listening."), and fewer than three questions, commands or criticisms during a 5-minute assessment.

In the PDI phase, typically 7–10 sessions, the parent develops skills to manage the child's behavior without resorting to physical coercion (Urquiza & Timmer, 2014). The therapist trains the parent to give only necessary commands, to make them clear and direct, and to give them only one at a time. Urquiza and Timmer (2014) provided an example of PDI coaching:

Therapist: It is now time to clean up the toys. Tell Robert to put the Legos back in the box.

Parent: Robert, it's time to clean up. Can you put the Legos back in the box? [Indirect Command]

Therapist: Make it a direct command.

Parent: Please put the Legos back in the box, Robert.

Therapist: That was a perfect Direct Command. Now Robert knows exactly what he is supposed to do.

Child: (Robert starts to put a couple of Legos in the box)

Therapist: Now Robert is putting Legos away like you told him.

Parent: Thank you for listening, Robert! [Labeled Praise]

Therapist: Excellent labeled praise. That will help Robert want to listen more in the future. (p. 127)

The therapist coaches the parent in using time-outs or strategies such as removing privileges when the child does not comply and in praising the child for compliance (Urquiza & Timmer, 2014). The intent of this phase is to make the process of giving commands and obtaining compliance predictable and safe for both parent and child. During PDI, therapists correct parents' mistakes more often than during CDI, and may coach parents with the exact words to use when children are noncompliant. PCIT treatment is complete when the parent has mastered the skills in both the CDI and PDI phases, and the child responds to the parent's efforts to manage the child's behavior.

PCIT has daily homework (Urquiza & Timmer, 2014). For five minutes each day, the parent has a "special playtime" with the child, using the skills learned during the CDI phase. At the end of each PCIT session, the therapist discusses with the parent which skills to target during the next week's play times. Special playtime is not to be given as a reward or taken away as a

punishment for the child's behavior; it provides time for practicing new parenting skills and fostering a secure attachment with the child.

PCIT has been adapted for working with children who have experienced trauma (Urquiza & Timmer, 2014). The therapist helps the parent to identify when the child's thoughts and feelings about trauma are being acted out in play and to respond appropriately by labeling the child's emotion or by creating a resolution to the play scenario that keeps the child safe. With the assistance of the therapist, the parent may also help the child with strategies to manage his or her feelings using breathing or relaxation techniques.

**Setting.** As initially designed, PCIT is conducted in a research or clinic setting that has two adjacent rooms with a one-way mirror on the adjoining wall. This arrangement allows the therapist to observe the play session and coach the parent from the adjacent room without being seen or heard by the child. In the adaptation of PCIT for in-home treatment, the therapist sits behind the parent to observe and coach as unobtrusively as possible (cite).

**Resources.** In the standard research or clinic setting, PCIT requires a microphone headset for the therapist and a wireless in-ear speaker for the parent (Urquiza & Timmer, 2014). This equipment allows the therapist to coach the parent from the adjacent room without the child hearing what is said. In-home PCIT does not use this equipment. Video recording equipment for taping sessions for assessment and supervision is useful but not required.

**Provider requirements.** Training in PCIT requires a master's or doctoral degree and licensure as a mental health provider ("Training Requirements for Certification as a PCIT Therapist", 2018). Training consists of 40 hours over five days, followed by the completion of two supervised cases before practicing independently. The developers recommend prior training in cognitive-behavior therapy and child behavior therapy. The PCIT International website sells

PCIT manuals (<http://www.pcit.org/store/c2/Manuals.html>). The University of California at Davis offers additional web-based training for implementing PCIT for traumatized children (“PCIT Web Course”, n.d.).

***Evidence base for intervention.*** PCIT is listed in both the CEBC and NREPP registries. The CEBC lists PCIT as an intervention for Disruptive Behavior Treatment; in 2013, it rated PCIT’s scientific reliability as 1 and its relevance for child welfare as medium (“Parent-Child Interaction Therapy [PCIT]”, 2017). In 2009, NREPP reviewed PCIT under its legacy criteria, and listed PCIT as having outcomes related to parent-child interaction, child conduct disorders, parent distress and locus of control, and recurrence of physical abuse (“Intervention Summary Parent-Child Interaction Therapy”, 2009).

PCIT has been implemented and studied with a variety of demographic populations, for a variety of presenting problems, and in multiple treatment settings. PCIT has been studied with parents of children who display disruptive or oppositional behavior, with foster parents and children, with children with intellectual disabilities and their parents, with maltreating or abusive parents and their children, and with at-risk children of mothers who have depressive symptoms (Timmer et al., 2011). PCIT has been studied in a community setting with low socioeconomic, ethnic minority children and families (Lyon & Budd, 2010) and in a home-based setting (Lanier et al., 2014).

Lyon and Budd (2010) found community-based PCIT effective in reducing children’s behavior problems and parental distress in low socioeconomic, racial and ethnic minority children and families. Fourteen families were referred for treatment from multiple sources: ten by schools and community mental health agencies, and four by self-referral. Of the children 50% were Black, 29% multiracial, and 21% Latino. Nine children (64%) were male. Children had a

mean age of 3.7 years (range 2–7). The children carried diagnoses of Oppositional Defiant Disorder (36%), ADHD Combined Type (29%), Disruptive Behavior Disorder/Not Otherwise Specified (DBD-NOS, 21%), ADHD Inattentive Type (7%), and combined DBD-NOS and Autism Spectrum Disorder (7%). Participant caregivers were 12 single mothers, one single father, and one married couple. Two of the single mothers were White foster mothers in the process of adopting their foster children. Eleven of the initial participants received some public assistance (e.g., Medicaid), and two were charged a reduced fee due to their financial status. To make treatment participation easier for families, investigators provided free transit passes, scheduled some evening sessions, and offered two locations at which treatment could occur. Two families dropped out after the initial assessment; the data include only the 12 who completed at least one treatment session.

Participants were assessed pre- and post-intervention (Lyon & Budd, 2010). Caregivers completed the CBCL (discussed in Chapter III), the Eyeberg Child Behavior Inventory (ECBI), and the Parenting Stress Index-Short Form (PSI-SF). The ECBI is a caregiver-report measure of disruptive behavior that includes scales for frequency of behavior (Intensity Scale) and the degree to which caregivers perceive behaviors as problematic (Problem Scale). The PSI-SF is a 36-item parent-report measure of strain in managing responsibilities and interactions with children; it includes scales for Parental Distress, Parent-Child Dysfunctional Interaction, and Difficult Child, as well as a Total Stress score. Because the investigators were interested in issues related to providing PCIT to underserved community populations, caregivers also completed the Therapy Attitude Inventory (TAI) and the Barriers to Treatment Participation Scale (BTPS) at the end of treatment (Lyon & Budd, 2010). The TAI is a 10-item self-report that assesses satisfaction with the therapy process and outcomes. The BTPS is a 58-item measure

about psychological and practice barriers to engaging in treatment. Forty-four items list possible barriers (e.g., “I thought treatment cost too much” or “I didn’t need treatment”), and 14 items describe critical events (e.g., “I lost my job ” or “Someone close to me became ill or died”) that might affect participation.

Lyon and Budd (2010) found that, despite efforts to reduce barriers to treatment, dropout was high (67%). Four families completed treatment; eight dropped out during treatment. Three of the dropouts completed CDI (the first phase of PCIT), and had at least one PDI (second phase) session. On average, completers progressed through the CDI phase in fewer sessions (6 versus 8) than non-completers. Three of the four completers had been self-referred.

For families that completed treatment, mean scores on all parent-report scales showed decreases in children’s behavior problems post-treatment (Lyon & Budd, 2010). Mean CBCL total and externalizing scores decreased from clinical levels to near average; the mean internalizing score, approaching clinical at assessment, decreased as well. Two completers initially showed clinical-level scores on the ECBI Intensity Scale, and the third scored one point below the clinical cutoff; all three showed clinically significant reductions after treatment.

In a study of children at high risk for maltreatment, Timmer et al. (2011) found PCIT effective in reducing children’s behavioral problems, including children whose mothers were clinically depressed. Participants were 132 predominantly CPS-referred children whose mothers reported either low or clinical levels of depression. Children averaged 4.47 years of age; 60% were male. Mothers averaged 27.8 years of age. Approximately half of the mothers and children were White/non-Hispanic (46% of children and 50% of mothers), 26% of children and 20% of mothers were Black, 24% of children and 20% of mothers were Hispanic/Latino, and 4% of children and 10% of mothers were of other races and ethnicities. The children had substantial



histories of suspected or documented maltreatment: 75% were referred by CPS and 48% were court-mandated to treatment.

Timmer et al. (2014) conducted pre- and post-intervention assessments using the ECBI, CBCL, and the Emotional Availability Scales (EAS). The EAS is an observational coding system for assessing the caregiver-child relationship. The EAS consists of six scales: Four parent scales measure sensitivity, hostility, intrusiveness and control, supportive presence, and two child scales measure responsiveness and children's involvement of parents in their play.

Dropout rates were high (Timmer et al., 2011). Half (50%) of non-depressive mothers and 36% of depressive mothers completed the PCIT intervention. Depressive mothers were significantly more likely ( $p = .03$ ) than non-depressive mothers to drop out before completing PCIT.

Timmer et al. (2011) found no differences, on average, between the depressive and non-depressive groups on the observed pre-test quality of parent-child interaction or post-test improvements in emotional availability, and no evidence of depressive symptoms interfering with mothers' acquisition of PCIT skills. Children of mothers in the depressive and non-depressive groups showed similar mean increases in emotional availability as measured on the EAS. The two groups of mothers showed similar mean increases in encouraged verbalizations and decreases in discouraged verbalizations as measured by the DPICS-II.

Following PCIT, mothers in both the depressive and non-depressive groups reported improvements in their children's behavior problems (Timmer et al., 2011). The means of the CBCL total, internalizing, and externalizing scores decreased from pre- to post-test ( $p = .01$ ), as did mean ECBI intensity and number of problems scores ( $p = .03$ ). Depressive mothers reported

significantly more severe behavior problems pre-treatment and greater reductions in behavior problems post-treatment than non-depressive mothers.

Mothers in the depressive group who completed the intervention experienced significant mean reductions ( $p = .01$ ) in depressive symptoms from pre-test to post-test (Timmer et al., 2011). Both pre- and post-intervention, mothers completed either the Symptom Checklist 90-R (SCL-90-R) or the Brief Symptom Inventory (BSI). Pre-intervention, all mothers in the depressive group scored above the clinical cut-off for depression, while all mothers in the non-depressive group had average or below average scores for depressive symptoms. Among mothers who completed the intervention, 79.3% of the depressive group no longer scored in the clinical range, and 3.8% of the non-depressive group scored in the clinical range for depression.

Timmer et al.'s (2011) study had limitations related to control groups and attrition. Including control groups of families with depressive and non-depressive mothers that did not receive PCIT (either by wait-listing them for PCIT or providing an alternate intervention) in the study design would have allowed the researchers to explore change over time in the depression symptoms of the depressive mothers and the non-depressive mothers not participating in PCIT. Also, although Timmer et al. expected the higher dropout rate for depressive mothers, it may have affected the high percentage of mothers whose depression remitted.

Lanier et al. (2014) explored PCIT effectiveness, differences in outcomes due to treatment settings, and factors related to dropout from PCIT. Overall, they found that PCIT delivered in-home had similar effectiveness to PCIT provided in a community office-based setting. One hundred and twenty families were referred for treatment from community settings. Among these families, 51% were White, 42% were Black, and 7% were other race/ethnicity. Ninety percent of participating caregivers were female; caregivers' mean age was 36. Mean

family income was \$19,500. The age distribution and the gender of the children were not provided. Since the study's intent was to replicate a community service model, families were not randomly assigned to a treatment setting, but were given the choice of receiving PCIT either at the office or in their homes. Sixty-seven families chose office-based treatment, and 53 chose home-based treatment.

Lanier et al. (2014) conducted pre- and post-intervention assessments using the ECBI, PSI-SF, the Behavioral and Symptom Identification Scale (BASIS), and the Global Assessment of Functioning (GAF). BASIS is a 32-item instrument that assesses for psychological problems in five areas: relation to self/others, depression/anxiety, daily living skills, impulse/addictive behavior, and psychosis. GAF scores are the clinician's subjective rating, on a scale of 0–100, of the psychosocial and occupational functioning of the participants.

PCIT was effective for families who completed treatment. Among the families that completed the program, Lanier et al. (2014) found improvements in children's behavioral problems and reductions in parental stress on all measures, on average. However, the majority of families dropped out during treatment: only 28% in office-based treatment and 33.9% in home-based treatment completed PCIT. Mid-treatment outcome scores showed no significant improvement for families that completed only the CDI phase.

Lanier et al. (2014) found that PCIT was effective when delivered both in an office and in the home. No significant differences were found between the home-based and office-based treatment groups before treatment. Additionally, few differences were found in the trajectories of change that families experienced based on treatment setting. However, for those who completed treatment, the rate of change was significantly different for two of the outcomes. While mean PSI scores for the two groups were not significantly different before treatment, families in office-

based PCIT showed a greater rate of change in mean PSI scores by the end of treatment. While initial BASIS scores were the same for both groups on average, only participants in office-based PCIT show a significant decrease during treatment. Changes in mean ECBI Intensity and Problem scores did not vary significantly by the treatment setting. Families that dropped out of treatment showed no significant improvement in any of the outcome measures regardless of whether PCIT was delivered at home or in the office.

Lanier et al. (2014) discussed the advantages and disadvantages of in-home PCIT. Home-based therapy is more convenient for families that have transportation difficulties or other children at home. The therapist develops an understanding of the home setting, and the parent learns skills in the setting in which they will be used. In-home therapy often has lower cancellation and no-show rates than office-based therapy. However, a chaotic home setting with more than one child or other family members present may increase the difficulty of working with the individual parent-child dyad.

***Parent-Child Interaction Therapy with homeless families.*** PCIT is a 14–20 session intervention; as noted, researchers have found no significant change for children and parents who do not complete treatment (Lanier et al., 2014). For many families in emergency shelters, where the average stay is seven weeks (Solari et al., 2016), completing PCIT would not be feasible unless sessions were conducted twice weekly. For families living in transitional housing, which has a maximum 2-year residency and a typical residency of 11–15 months (Gubits et al., 2016), the time frame of PCIT would be feasible.

PCIT studies reported high dropout rates, with fewer than half of study participants completing treatment. Despite offering incentives that included free transit passes and evening appointments, Lyon and Budd (2010) reported a 67% dropout rate among low-income, racial and

ethnic minority families. Timmer et al. (2011) reported dropout rates of 64% for depressive mothers and 50% for non-depressive mothers in a sample of primarily CPS-referred families. In a study comparing office-based and home-based PCIT in a racially diverse sample, Lanier et al. (2014) reported that 72% of families in office-based treatment and 66% in home-based treatment dropped out during treatment.

As Lanier et al. (2014) noted, delivering PCIT in-home allows the therapist to get a sense of the home setting, while the parent learns skills in the environment in which they will be used. When PCIT is implemented in a clinic setting, the child cannot hear the therapist coaching the parent; in the home, the child can hear the therapist's guidance. While much of the verbal interaction between the parent and a therapist might be incomprehensible to an infant, a child who is 2–6 years old will understand at least some of the coaching. In Lanier et al.'s (2011) study comparing the effectiveness of in-home and community-based PCIT, some therapists conducting in-home PCIT reported that parents were resistant to coaching, and “chose not to say the positive statements that the therapist asked them to repeat in front of their child” (p. 697). A child might interpret this parental reluctance as rejection, which could further damage the parent-child relationship. Furthermore, the presence of siblings, which might hamper effective engagement between parent and child, must be addressed for in-home PCIT.

**Theraplay.** Theraplay is an interactive, directive, short-term, attachment-based play therapy intervention for children from birth to 18 years and their parents/caregivers. While Theraplay may be implemented with children of all ages, the focus in this review remains on its use with young children. Theraplay therapists attempt to replicate the natural interactions that occur between a parent and young child (Booth & Winstead, 2015). It is emotionally focused, rather than insight-oriented or cognitive. The intervention is an office- or clinic-based model that

is implemented in structured, 30-to-45 minute weekly sessions, typically for 18–24 weeks, with four follow-up sessions over the year following treatment.

***Intervention goals.*** The primary goal of Theraplay is “to create a secure attachment, including positive internal working models for both parents and child, the capacity of self-regulation, good social skills, the ability to learn, and long-term mental health” (Booth & Winstead, 2015, p. 142). The intervention aims to increase the child's felt safety/security, the capacity to regulate affect (beginning with co-regulating with the therapist, and then with the parent), and the feeling of a positive body image. It also aims to increase the parent’s capacity for behaving empathetically and reflectively toward the child, for helping the child deal with stressful events, and for setting expectations and limits in a clear yet supportive way.

***Intervention process.*** Theraplay emphasizes “parental involvement through structured, attachment-based play, guided challenge, social engagement, playful regulation of affect, and high levels of nurture” (Wettig, Coleman, & Geider, 2011, p. 27). Theraplay activities address four dimensions that are seen as fundamental to healthy parent-child relationships: *structure*, *challenge*, *engagement*, and *nurture* (Booth & Winstead, 2015). During the pre-treatment assessment of the child and family, the therapist identifies underdeveloped or dysfunctional dimensions. Each Theraplay session involves a specific set of therapeutic activities that the therapist chooses to address particular child needs and clinical concerns. The activities are initially based on the assessed developmental age of the child, rather than his or her chronological age. Unlike other forms of play therapy, Theraplay does not use toys. The supplies used for activities include items such as lotion, powder, cotton balls, bubbles, scarves, and balloons.

The dimension of *structure* or routine creates a sense of predictability and security for the child (Booth & Winstead, 2015). Structure is evident in the organization of Theraplay sessions, which have a definite beginning and end, a set length, and a pattern of interactions. Sessions begin with an entrance greeting or song, and an inventory identifying positive features of the child (e.g., curly red hair, big green eyes, freckles on the face, which the therapist might count). Next, the therapist or parent provides "caring of hurts," in which the therapist or parent puts lotion or a Band-Aid on any scrape or bruise that they see on the child's arms or face, or anything that the child identifies, whether visible or not, as a boo-boo (Munns, 2009, p. 267). The middle of the session consists of a series of activities that address the four dimensions, and the session ends with a goodbye song or special handshake. The therapist also provides structure by leading the activities in a clear way that the child can understand, and making rules for behavior, such as "no hurts allowed." Activities focused on structure include

- Clap patterns: The therapist or parent makes a pattern of clapping sounds with the hands, and the child copies it.
- Body outline: While the child lies on a large sheet of paper, the therapist or parent draws the child's outline with a felt-tipped marker. Therapist, parent, and child then fill in the child's physical features.

Activities related to structure are particularly important for children who are dysregulated or impulsive, or whose experience has been chaotic.

The dimension of *challenge* relates to the child's need to explore and face challenges, which, when accomplished, lead to a sense of mastery and self-confidence (Booth & Winstead, 2015; Munns, 2009). In Theraplay, challenging activities are geared to the child's developmental

capabilities so that he or she can succeed. Challenge activities that Munns (2009) describes include these:

- Balloon tennis: Child and adult(s) try to keep a balloon in the air by hitting it back and forth. The goal may be to hit the balloon a specific number of times.
- Ping-Pong ball blow: Child and adult(s) lie on the floor on their stomachs facing each other. The therapist places a Ping-Pong ball in the middle, and each person tries to blow the ball toward another person and away from herself.
- Straw wars: Child and adult(s) each get a drinking straw and several Q-tips. The straw is “loaded” by placing the Q-tip in one end, and the Q-tip “fired” by blowing it out the other end of the straw. The child and adult(s) can be challenged to hit a target such as a door.
- Toilet paper bust-out: The therapist and parent wrap the child’s arms and body in a few layers of toilet paper, and then challenge the child to “bust out,” expressing delight in her strength when she does.

Challenging activities often require some cooperation or competition with the therapist or parent and may allow an aggressive child to release tension.

The dimension of *engagement* relates to creating a warm, playful connection with the child (Munns, 2009). Engagement helps the child to know that, while she or he has boundaries and is separate from other people, the child is not alone (Booth & Winstead, 2015). The Theraplay therapist may use activities that involve surprise or novelty to create delight in the interaction with the child. Engagement starts with a fun entrance to the session (e.g., marching in to music, or walking in backwards) and continues with activities that are mutually enjoyable and geared to the child’s needs. Engagement activities that Munns (2009) describes include these:



- Dancing in: The child stands on the adult's feet, with the adult holding the child in ballroom dance position. The adult and child sing a song together while the adult slowly "dances" with the child.
- Mirror, mirror on the wall: Child and adult stand face to face. When the adult moves her arms or changes her facial expression, the child mimics the movement and expression.
- Twizzler test: Using Twizzler candies (or fruit roll-ups or candy canes) as a unit of measurement, the child, parent, and therapist discuss how many Twizzler lengths they like to have between them. This game is used to explore boundaries and appropriate physical proximity for various types of relationships.

Engagement is crucial for working with children who are withdrawn or depressed.

The dimension of *nurture* is the most important of the four dimensions, because all children need nurture to thrive (Booth & Winstead, 2015; Munns, 2009). Every Theraplay session includes applying lotion to or bandaging hurts or boo-boos. Nurturing activities might include these:

- Butterfly, elephant, and Eskimo kisses: A butterfly kiss is given by fluttering the eyelashes against a child's cheek or forehead. An elephant kiss is given by putting one fist on top of the other in front of the mouth to make a "trunk," and then using the trunk to "kiss" the child's cheek. An Eskimo kiss is given by gently rubbing the tips of noses together.
- Cotton ball soothe: The child lies down with his or her head on a pillow and eyes closed. The adult gently strokes the child's face with a cotton ball, either silently or while speaking about the child's unique features, e.g., "cute button nose, long dark lashes, little shell ears."
- Feeding: The child sits either on a pillow facing the adult or in the adult's lap. The adult feeds the child a small snack or drink, paying attention to each bite and noticing when the

child wants more. An alternate involves the therapist hiding small snacks such as M&Ms or goldfish crackers on the child for the parent to find and feed to the child (Munns, 2009).

All nurturing activities are intended to be soothing or calming for the child.

While not a part of Theraplay treatment per se, Buckwalter (n.d.) suggests completing the Adult Attachment Interview (AAI) with mothers who are not fully engaging in treatment with their children. Knowing the mother's adult attachment style may help the therapist understand why a mother has difficulties participating in therapeutic activities. The therapist can then work with the mother to change how she relates to her child.

**Training.** Certification in Theraplay requires a four-day introductory training, a three-day intermediate training, and 40 hours of supervised practicum ("About our Training", n.d.). In order to become certified, therapists must be fully licensed, master's- or doctoral-level mental health professionals. Manuals are available online from the Theraplay Institute (<https://www.theraplay.org/index.php/j2store>).

**Location.** Theraplay is typically conducted in an office or clinic setting. The recommended treatment room is a 12'x12' room containing only a small sofa, soft gym or yoga mats on the floor, and a cabinet or closet for supplies (Booth & Winstead, 2015). Providing few additional furnishings or toys in the room reduces distractions. Equipment for videotaping sessions and playing videos is highly recommended. Ideally, an adjacent observation room with a one-way mirror will allow caregivers to observe when they are not participating in a session. Theraplay has been conducted in a variety of settings, including in a domestic violence shelter (Bennett et al., 2006).

**Evidence base for intervention.** Theraplay is listed in both the CEBC and NREPP. The CEBC lists Theraplay as an intervention for infant and toddler mental health (0–3), and rates its

scientific reliability as 3 and its relevance for child welfare as medium (“Theraplay”, 2017).

NREPP lists Theraplay under its current guidelines as having effective outcomes for internalizing problems, and promising outcomes for autism spectrum disorder and symptoms (“Theraplay Program Description”, 2016).

Siu (2009) found group Theraplay to be effective in reducing internalizing behavior in elementary school children in Hong Kong. Participants were 46 children from one elementary school whose scores, on average, were above the clinical cutoff on the internalizing behavior subscale of the CBCL. The children’s mean age was 7 years. Participants were randomized to either the intervention group ( $n=22$ ) or a wait-list control group ( $n=24$ ). Twelve children in the intervention group (55%) and 13 children in the control group (54%) were female. Siu provided no additional demographic information. The intervention group children received eight weekly, 40-minute sessions of group Theraplay (Siu, 2009). Theraplay therapists selected activities that "incorporated a high degree of physical interaction, playfulness, and a strong sense of connection among participants" (p. 6). As in individual Theraplay, mothers were invited to observe the first several sessions and to participate in later sessions. Before treatment, intervention and control groups had similar internalizing behavior scores per maternal report on the CBCL. Post-intervention, Siu found that the intervention group had significantly lower mean internalizing scores than the control group ( $p < .01$ ); the intervention group’s mothers reported, on average, less depression, anxiety, and somatization in their children post-treatment than mothers of control group children.

A major limitation of Siu’s (2009) study is the difficulty in generalizing from children in Hong Kong to homeless children in the United States. Siu provided no demographic data on the race or socioeconomic status of the participants. Even if participants were racial or ethnic

minorities and of lower socioeconomic status, the implications of those sociocultural factors for families in Hong Kong might be vastly different from their significance in the United States.

Bennett, Shiner, and Ryan (2006) discussed their development of a group intervention based on Theraplay for children and their mothers in a domestic violence shelter in Canada. They noted that early approaches to intervention in shelter settings involved separate counseling groups for mothers and their children; these are still common. More recently, programs have been developed that work with the mother and child together. Such programs address both the mental health problems that children exposed to domestic violence may experience, and the strengths and protective factors that may help the child. “These strengths include attachment, self-concept and emotional regulation needs, which are believed to lower the risk of future health problems in these children” (Bennett et al., 2006, p. 41). When developing a group program for shelter use, they selected the Theraplay model because of its emphasis on enhancing the mother-child relationship and improving the child's capacity for regulation. An aim of Group Theraplay is to promote warm, trusting relationships within the group, which Bennett et al. (2006) felt was particularly well suited for the shelter setting.

Bennett et al. (2006) developed a 6-week intervention with two sessions per week, the first session with the children and the second with mothers and children together. Each week's sessions had a theme; the sessions incorporated Theraplay activities for both mother-child dyads and the whole group that supported the week's theme while keeping the sessions playful, engaging, and nurturing. Week 1 focused on the purposes of the group: to have fun with their own and other families, to have a safe space for sharing feelings, and to learn about domestic violence. Several Theraplay activities common to most sessions, such as a physical inventory of the child, caring for hurts, and food sharing were introduced. Week 2 focused on learning about

violence, increasing the children's understanding of domestic violence and violence in the larger society. Week 3 focused on learning about feelings, including the full range of feelings that human beings experience and those they may have about violence. Week 4 explored dealing with anger, discussing the relationship between feelings and behavior, and learning how to manage angry feelings. Bennett et al. noted that, because some children believed that expressing anger always involved injurious behavior, discussing healthy and unhealthy ways of responding to anger was important. Week 5 focused on building supportive relationships, and emphasized building the child's awareness that social supports were available to help her or him cope with domestic violence. Week 6 focused on enhancing the child's connection with his or her own family by exploring family rituals, values, and experiences.

Participants for the initial implementation of Bennett et al.'s (2006) intervention were 15 children and 10 mothers. The children's ages ranged from 6 to 12. The mothers had experienced a range of domestic violence, including physical and sexual assault and emotional abuse. Bennett et al. did not identify other demographic characteristics of participants. Bennett et al. reported that the majority of participants attended six or more of the twelve scheduled sessions; they did not indicate why participants missed some sessions.

Bennett et al. (2006) conducted a process evaluation to determine how the intervention was received, which activities were most enjoyable, and whether activities were effective for meeting program goals. They found that the participants enjoyed the fast-paced, active nature of the sessions, and that the children particularly enjoyed the mother-child sessions. "In some instances, the children expressed annoyance toward their mothers if the mothers were late for sessions" (Bennett et al., 2006, p. 47). Bennett et al. recognized the limitations of not assessing participants for change, and indicated that future assessment would be necessary:

Although the...program cannot claim to achieve positive outcomes in terms of current behavioral adjustment, prevention of future clinical problems, or even change attitudes toward violence, it can claim to improve the quality of life for mother and children during a short shelter stay. (Bennett et al., 2006, p. 47)

Limitations of Bennett et al.'s (2006) study include that it was conducted in Canada. Additionally, Bennett et al. provided no demographic data on the race or socioeconomic status of the participants. If participants were racial or ethnic minorities or lower SES families, the implications of those sociocultural factors might be different for Canadian families than for families in the United States.

***Theraplay with homeless families.*** Theraplay is typically an 18–24 week intervention. For many families in emergency shelters, where the average stay is seven weeks (Solari et al., 2016), completing a standard course of Theraplay would not be feasible. However, as noted, Siu (2009) found that an 8-session course of Theraplay led to reductions in internalizing behavior in school children in Hong Kong; some children might therefore benefit from a shorter course of Theraplay. For families living in transitional housing, which has a maximum 2-year residency and a typical residency of 11–15 months (Gubits et al., 2016), the time frame of Theraplay would be feasible. Wettig et al. (2011) found that some children required between 43 and 66 sessions to reach therapeutic goals; this longer treatment would also be feasible for many transitional housing residents.

Theraplay typically begins with several therapist-child sessions that the mother observes through a one-way mirror (often with a second therapist who comments on the purpose of the activities in the session), before the mother gradually becomes more involved in the sessions, and eventually leads the activities. This observation might be easier in an agency setting than in a

home or shelter setting. Depending on the child's age, temperament, and attachment style, he or she might be distracted by the mother observing in the same room, and be less able to engage with the therapist.

Theraplay has been adapted for use with siblings, and could be implemented with entire families in shelter or transitional housing. In working with siblings in adoptive families, Weir et al. (2013) used group Theraplay activities with the entire family, or one-to-one activities in parallel, with either a parent or a therapist doing the activity with each child. Theraplay is recommended for families with high levels of sibling rivalry (Munns, 2009). In many families, siblings vie for their caregiver's attention. When a family becomes homeless, the stresses on the caregiver may render her less attentive and emotionally available, leading to more competition between siblings for her attention.

With its focus on co-regulation with the parent as a means of building the child's capacity for regulation, Theraplay seems particularly relevant for homeless children, who may need more help with regulation since becoming homeless. Both the process of becoming homeless and the experience of living in a shelter are chaotic, and disrupt the routines of young children and their families. Mothers who are trying to navigate the homeless system with children in tow may have difficulty responding sensitively to their children's needs for nurture, particularly when the need for soothing and co-regulation is less obvious than the need for food, clothing, and shelter.

## **Summary**

In this chapter, the literature on five evidence-based interventions for young children was reviewed to assess the feasibility and appropriateness of the interventions for use with families living in emergency shelters or transitional housing. These interventions vary considerably in the specified time frame for treatment, from 10 sessions for ABC to approximately 50 for CPP. All

five of the interventions would be feasible as in-home interventions for families living in transitional housing, and all but CPP might be adapted to the time frame of the average stay in emergency shelter. Each of these interventions takes a different approach to fostering healthy attachment relationships; some interventions will better meet the needs of specific clients – and better fit the orientations and personalities of specific therapists – than others. Chapter VI begins with a discussion of evidence-based treatment, including concerns and questions about EBT resulting from this review. It continues with recommendations for policy, practice, and research that focus on increasing the quality and availability of mental health treatment for homeless young children and their families.



## **CHAPTER VI**

### **Discussion**

This review of the literature was conducted with two objectives: to explore the relationship between family homelessness and the mental health of young children and their caregivers (usually mothers) through the lens of attachment theory; and to review evidence-based mental health interventions that might be implemented in emergency shelter or transitional housing settings to address the mental health needs of young children, in part by strengthening their attachment relationships. This chapter includes a discussion of evidence-based treatment; recommendations for policy, practice and future research; limitations of this review; and my experiences related to family homelessness.

#### **Evidence-based Treatment**

In the reality of modern managed care, insurance companies decide which mental health treatments they will cover; their decisions determine which treatments are available to families who rely on insurance to cover treatment costs. The trend in mental health care, particularly in community mental health agencies that have many clients covered by Medicaid, is to provide evidence-based treatment (EBT). I chose to review evidence-based interventions in this thesis based on my hope that Medicaid would reimburse for them. As outlined in Chapter V, to be listed as an evidence-based intervention in registries such as CEBC and NREPP, an intervention must have a manual that describes proper implementation, and randomized controlled trials (RCTs) that demonstrate the intervention's efficacy.

**Efficacy and effectiveness.** Researchers who conduct studies of mental health interventions discuss *treatment efficacy* and *treatment effectiveness* (Nathan, Stuart, & Dolan, 2000). *Efficacy* refers to the performance of an intervention under ideal, highly controlled circumstances; *effectiveness* refers to its performance in real-world conditions. Nathan, Stuart, and Dolan (2000) noted that “efficacy studies emphasize internal validity and replicability; effectiveness studies emphasize external validity and generalizability” (p. 935). Findings on the efficacy of an intervention to treat a particular disorder generally derive from studies conducted in university research settings, in which well-supervised graduate students trained in intervention fidelity serve as therapists and participant groups are carefully selected to minimize co-occurring conditions or confounding variables. However, an intervention that is efficacious when implemented in a controlled setting may not be similarly effective when implemented by practicing therapists with heavy caseloads and limited supervision in community mental health settings. Some researchers who conducted studies in community settings to evaluate the effectiveness of one of the reviewed interventions attempted to train practicing therapists to the same level of fidelity as their graduate student therapists; their results were mixed (Lanier et al.; 2014; Yarger et al., 2016).

**Treatment dosage.** Evidence-based intervention models call for a specific treatment dosage, usually described as a number of sessions or weeks of treatment (e.g., 10 sessions for ABC, 16–20 sessions for CCPT, 50 sessions for CPP, 10–20 sessions for PCIT, 18–24 sessions for Theraplay). A perceived benefit of EBTs is that treatment is completed after the specified dosage. However, the treatment dosage in RCTs is often different from the specified dosage, due either to some aspect of the study methodology or to participants’ missing scheduled sessions. In a study of CPP, Cicchetti et al. (2006) reported that, although therapists scheduled weekly

sessions over the course of a year, they conducted an average of 22 sessions of CPP per participant due to cancellations. Although the therapists conducted, on average, fewer than half of the sessions scheduled, Cicchetti et al. (2006) found significant increases in attachment security and organization. While researchers from some studies (Baggerly, 2004; Toth et al., 2006) reported the mean number of sessions conducted or, in the case of PCIT studies, the mean number of sessions required to complete treatment, few reported the range of sessions conducted. In a study of Theraplay, Wettig et al. (2011) reported an average of 18 sessions to reach treatment goals, but noted that several participants required between 43 and 66 sessions—three to four times the average dosage—to meet goals. Individuals will respond to a therapeutic intervention, manualized or not, at different rates. If the therapeutic goal is to resolve the child's problems, therapists should be prepared to continue a treatment that appears to be effective beyond the specified time frame.

**Meeting treatment goals.** The literature on the evidence-based interventions reviewed here reported on the efficacy or effectiveness of treatment for the treatment period of the evaluation study. All studies reported statistically significant change in variables of interest, either between the intervention group and the control group (between-group change), from pre-test to post-test for the intervention group (within-group change), or both. However, few studies indicated that all participants in the intervention group improved (within-individual change). Studies of PCIT were unusual in that the researchers reported that treatment was provided until behavioral goals were met. However, given the high attrition rates, one wonders whether the participants who dropped out were making progress in treatment.

In studies that measured attachment security and organization, large percentages of children still had insecure or disorganized attachments post-intervention. While Bernard et al.

(2012) found that, post treatment, the ABC intervention group had significantly higher rates of secure and organized attachment post-intervention than the control group, 32% of children in the ABC group remained classified as disorganized and 48% as insecure post-intervention. Similarly, while Cicchetti et al. (2006) found that the CPP intervention group had significant post-intervention decreases in disorganization compared to the control group, 32% of CPP group children remained classified as disorganized post-intervention. In other words, not every child got better. This is an acceptable outcome in an RCT, and may be an exciting outcome for researchers who hope to demonstrate their intervention's positive effect on attachment style. However, it is not an acceptable outcome in clinical practice with a child whose attachment remains disorganized or insecure following treatment. One wonders how the researchers discussed treatment results with the parents of children whose attachment styles did not become secure or organized. Did they provide additional treatment using the studied intervention model, or suggest a different treatment approach? The expectation that training in ABC and CPP would address these questions is both fair and reasonable.

**Cultural appropriateness.** The effectiveness of manualized evidence-based interventions may be limited by the sociocultural contexts of their developers. The developers of the interventions reviewed were middle-class, White academics trained in western medical, psychological, and developmental models. Some of their interventions may not be in accord with the cultural beliefs, values, and preferences of clients from varied sociocultural contexts. In their book on CPP, Lieberman and Van Horn (2011) spoke to this issue:

The lively debate about the value and limitations of evidence-based treatment bears witness to the ongoing salience of a major question: how to reconcile treatment that is

individually tailored to the needs of the child with adherence to manualized interventions that demonstrated efficacy in randomized trials. (p. 319)

Lieberman and Van Horn (2011) referred specifically to the increasing sociocultural diversity in the United States, the tension between a therapist's understanding of the importance of attending to an individual client's race, ethnicity, SES, religious beliefs, and immigration/ acculturation experience, and that therapist's knowledge that the evidence for the intervention being implemented might have come from a sample with markedly different characteristics.

One way in which sociocultural differences may present in RCTs conducted with racial and ethnic minority children and families is attrition. Several studies of interventions that were conducted with low-income, racial and ethnic minority, single parent families had high rates of participant attrition during treatment (Cicchetti et al., 2006; Lanier et al., 2014; Lyon & Budd, 2010; Timmer et al., 2011). High dropout occurred in home-based and in office-based interventions and in community settings with practicing clinicians as well as in university research settings where many therapists were graduate students. In a study of PCIT with predominantly low-income Black and Hispanic participants, Lyon and Budd (2010) found that high dropout occurred even when researchers offered free transit passes, evening appointments, and two options for treatment location. Lyon and Budd (2010) reported that one Black mother "explained that she believed PCIT represented a 'white' parenting method," and the grandmother of an Hispanic child expressed intense disapproval of the therapy; both participants dropped out of treatment (p. 664). The therapists in Lyon and Budd's (2010) study were White and Asian American. In a study of retention for children receiving evidence-based treatment (e.g., PCIT, trauma-focused cognitive behavioral therapy) at a community mental health agency where 71% of clients were White and 29% were Black ( $n = 447$ ), Miller, Southam-Gerow, and Allin (2008)

found that race was one of the most robust predictors of treatment completion; significantly fewer Black clients completed treatment than White clients. Miller et al. (2008) reported that two-thirds of the staff at their agency were White, but did not indicate whether that two-thirds represented clinical staff or total staff. In a study of CPP with maltreating families, three-quarters of whom were racial/ethnic minorities, Cicchetti et al. (2006) reported that almost half of participants randomized to the intervention groups did not engage in treatment; the race/ethnicity of the therapists in their study was not identified.

Most RCTs provided detailed information about the race/ethnicity of the participants (Cicchetti et al., 2006; Kot et al., 1998; Stronach et al., 2013; Timmer et al., 2011; Toth et al., 2006; Tyndall-Lind et al., 2001; Yarger et al., 2016), or stated why they were unable to provide those data (Bennett et al., 2006). The only studies that reported the race/ethnicity of the therapists were two that examined attrition (Lyon & Budd, 2010; Miller, Southam-Gerow, & Allin, 2008). However, a third study that examined attrition did not report the therapists' race/ethnicity (Lanier et al., 2014). It appears that therapists' race/ethnicity was viewed as unimportant and inconsequential to the treatment. Given the pervasiveness of racial inequality and White privilege in the United States, and the importance of the relationship between client and therapist in psychotherapy, researchers should be attending to the race/ethnicity of the therapists implementing interventions in RCTs and in community settings. One possibility deserving serious consideration is whether RCTs (or psychotherapy in general) conducted with largely racial/ethnic minority populations might have less attrition were more clinicians of color implementing the interventions.

An alternate explanation for the seeming inattention to the race/ethnicity of therapists in RCTs may be that few therapists of color were available in the university settings in which RCTs

were conducted. The interventions reviewed in this thesis were developed and are being studied by psychologists who hold academic positions in university psychology departments. In 2017, 89.5% of psychologists in the United States were White (Labor Force Statistics, 2017). If the racial distribution for psychology graduate students is similar to that of all U.S. psychologists, few graduate students from racial/ethnic minorities may be available to act as clinicians in RCTs.

**Funding for RCTs.** Conducting a randomized controlled trial requires funding to support the principal investigators and their graduate students; to pay for labs, offices, and transportation to research sites; to purchase assessment instruments, playroom toys, and other materials; and, in some cases, to provide financial incentives (e.g., gift cards, transit passes) for participants. Only some of the RCTs for the reviewed interventions listed their funding sources. The funding sources included governmental agencies including the National Institutes of Health (NIH), National Institutes of Mental Health (NIMH), and the Substance Abuse and Mental Health Services Administration (SAMHSA); internal university research organizations; and private foundations such as the Consuelo Foundation, the Coydog Foundation, and the Lisa and John Pritzker Family Fund. Most studies of ABC and CPP reported funding from NIH, NIMH or SAMHSA. The studies for CPPT, PCIT, and Theraplay that reported funding sources listed primarily university research organizations and private foundations as funders.

**Problems with the current understanding of evidence base.** Psychologist Jonathan Shedler, who has written about the evidence base for psychodynamic psychotherapy, has questioned the use of the term evidence-based to describe current manualized psychotherapy models:

Evidence-based medicine (EBM) was supposed to represent the convergence or intersection of 1) relevant scientific evidence, 2) patients' values and preferences, and 3)

the experience and clinical judgment of the practitioner. What has happened to these ideas in the field of psychotherapy? “Relevant scientific evidence” no longer matters, because proponents of so-called evidence-based therapies ignore evidence for therapy that is not pre-scripted, manualised therapy. ... “Patients’ values and preferences” also do not matter, because patients are not being informed and offered meaningful choices. They may be offered only brief manualised treatment and told it is the “gold standard” of care. “Clinical judgment” also no longer matters, because clinicians are expected to follow manuals rather than exercise meaningful clinical judgment. They are being asked to function as technicians, not clinicians. (Shedler, 2015, p. 57).

Shedler is not alone in his concerns. In addition to voicing similar concerns about the importance of clinical judgment and attending to client values and preferences, the National Association of Social Workers (n.d.) has argued against the seeming insistence on RCTs as the primary evidence base for EBTs:

Randomized controlled trials (RCT) are frequently viewed as the gold standard for the evaluation of interventions. However, it is not always possible or ethical to conduct RCT in social, health, and human services, and thus there is a lack of that type of research evidence for some interventions provided by social workers. Qualitative research can enhance quantitative research and help us better understand cultural issues and contexts related to interventions. (para. 7)

The literature has few peer-reviewed studies that evaluate mental health interventions for young children using a mixed methods (i.e., both quantitative and qualitative) approach although qualitative information and case studies are available in books on several of the reviewed interventions.



## **Implications for Policy and Practice**

**Knowledge base.** To work effectively with young homeless children and their families, clinicians require a wide body of knowledge. They should have training in child development, attachment theory, trauma theory, and the intergenerational transmission of attachment and trauma. They should understand the structural causes of poverty, the individual factors that may force an impoverished family into homelessness, and the types of deprivation, trauma, and loss that homeless families are likely to have experienced. Clinicians who work with school-aged children in public schools, particularly in cities with high rates of homelessness, should be aware that an estimated 1 in 30 children is homeless each year. Therefore, many of the low-income children with whom they work may have experienced or may currently be experiencing homelessness or housing instability.

**Assessment in emergency shelters and transitional housing.** Mental health screenings for children and their mothers should be a part of the intake procedures or general health screenings in homeless shelters and transitional housing programs. Studies have found that between 10%–26% of homeless preschoolers and 24%–40% of homeless children aged 6–11 had mental health problems requiring clinical evaluation (Bassuk et al., 2015). In a study of a pilot mental health screening program for families entering Florida homeless shelters, Lynch et al. (2015) found that 23% of children under the age of six and 33% of children ages 6–18 who were screened scored above the clinical cutoff on validated assessment instruments.

Despite the evidence of need, children's mental health may not routinely be assessed at emergency shelter or transitional housing intake. In a study of a pilot program for homeless families, Donlon, Lake, Pope, Shaw, and Haskett (2014) found that only one of 11 homeless shelters in Wake County, North Carolina asked any questions about children's functioning

during family intakes. In discussing services provided by transitional housing programs, Gubits et al. (2016) noted that mental health services, if provided, tended to focus on adult wellbeing, with child outcomes seen as “more distal outcomes” (p. xxi).

Additionally, homeless mothers of infants and young children may not be aware of their children’s mental health needs. Noting the high percentage of homeless parents with less than high-school educations, Lynch et al. (2015) suggested that some parents may not recognize young children’s behaviors as reflecting a mental health disorder. Lynch et al. found that parents were less likely to give consent for screening younger children than older children; 30% of children aged 0–5 years and 48% of children aged 6–17 years were screened. In a qualitative study of homeless families’ experiences in shelters, Anthony et al. (2018) found that mothers did not identify their infants and young children as being affected by living in a shelter, or as having mental health problems requiring treatment. Mothers entering shelters or transitional housing may be overwhelmed by the stresses associated with being homeless, and may be more focused on children’s urgent physical health needs than on their mental health needs. Providing education to homeless mothers about normal infant and child socioemotional development, and the importance of early childhood experiences, including attachment, to later socioemotional and academic functioning, might help some mothers of young children to recognize that their children are having difficulties, or help them to understand the value of mental health screening and treatment.

Shelters that do not have sufficient funding for on-site mental health services might develop partnerships with psychology departments at local universities. Doctoral programs in psychology require students to take several courses in assessment, often associated with practica. Emergency shelters might arrange with faculty to have students do assessments at the shelters as

part of their practicum. While trained clinicians must complete some mental health assessments, screening instruments are available that non-clinical staff in shelters or transitional housing could administer. These parent-report forms screen for socioemotional issues related to attachment and regulation in children ages 0–5. Many are written at a 3<sup>rd</sup>–6<sup>th</sup> grade reading level, so they would be accessible to parents with limited educations. Shelter staff could be trained to explain the purpose of screening, provide screening forms to parents, and collect them to return to a clinician for scoring, interpretation, and, if indicated, a full diagnostic assessment and treatment.

**Continuity of care.** Continuity of mental health care across housing situations is vitally important for homeless or unstably housed children and their families. As Bowlby (1988) noted, the relationship that a client develops with a therapist is an attachment relationship:

In providing his patient with a secure base from which to explore and express his thoughts and feelings the therapist's role is analogous to that of a mother who provides her child with a secure base to explore the world (p. 140).

For some mothers and children, the relationships that they form with their therapists may be their first experiences of healthy attachment relationships. For a child and mother who are working to repair attachment difficulties or heal from trauma, the sudden loss of their therapist due to a move may be distressing and detrimental to the treatment goals.

One of the questions I considered in reviewing mental health interventions was whether an intervention could be completed within the time frame that a homeless family would typically spend in emergency shelter or transitional housing. Moving from one location to another, whether from emergency shelter to transitional housing, or from transitional housing to permanent housing, often disrupts services that a family is receiving, including mental health care. The non-profit organizations that run emergency shelters and transitional housing programs

may contract with community mental health agencies (CMHAs) to provide services, and families moving from one housing program to another may find that their new housing does not contract with the same CMHA as their previous housing. Alternately, when families move out of homelessness into rapid rehousing or other permanent housing, supportive services such as mental health care may no longer be provided, or may be provided for only a limited time. While moving to permanent housing achieves the goal of ending a family's homelessness, it may not resolve any mental health problems that children experienced while they were homeless.

### **Recommendations for Future Research**

**Use research studies to support theoretical basis for interventions.** While the literature on the interventions reviewed described the interventions as having an attachment focus, the measures used in many studies of the interventions did not assess for child attachment style, organization, or strength, pre- and post-intervention. Researchers who investigate mental health interventions that claim attachment theory as a theoretical underpinning should include assessments of attachment security and/or organization in their studies. Studies of ABC and CPP have shown increases in attachment security. While proponents of Theraplay and PCIT state that these interventions are grounded in attachment theory, and studies of CCPT refer to enhancement of attachment relationships, research studies of these interventions that have been conducted to date have not measured attachment. Assessment instruments for attachment are more time-consuming, more personnel-intensive, and require more training to implement than the maternal-report or self-report instruments commonly used in clinical practice, particularly at CMHAs. Research studies may be the best opportunity for evaluating whether an intervention has a significant effect on attachment security.

**Study relationships between assessment instruments.** Many instruments for assessing attachment in infants and young children may be too time-consuming or personnel-intensive to implement in community mental health settings. Research studies should explore possible links between assessments of attachment security and organization (e.g., SSP, AQS, TAQ) and scores on standardized instruments (e.g., CBCL, Ages and Stages Questionnaire) that are commonly used in clinical practice. Since different styles of attachment predict different types of emotional and behavioral problems in children, studies that use the CBCL could analyze not only total CBCL scores, but the broad-band internalizing and externalizing subscales and the narrow-band areas of concern (e.g., withdrawn, anxious/depressed, aggressive) to test whether associations exist between attachment style and specific areas, or even specific items, on the CBCL. Findings could be helpful to therapists in CMHAs, where parental-report instruments are often used to gather information about young children and the parent-child relationship.

**Study populations with greatest needs.** Research on mental health interventions for families with young children should be conducted using participants from the populations most in need of mental health services. To control for confounding variables associated with poverty and adversity, some research on interventions has been conducted with middle-class, predominantly White samples. In a study of the efficacy of CPP in fostering attachment security in children with depressive mothers, Toth et al. (2006) and Cicchetti, Toth, and Rogosch (1999) selected a middle-class sample, which meant that the sample was also predominantly White and married. While Toth et al.'s (2006) and Cicchetti et al.'s (1999) findings suggested that CPP was similarly efficacious with both depressive and non-depressed mothers, generalizing from their study to a low-income or homeless population is difficult, because low-income and homeless women have different sociocultural and demographic characteristics and higher rates of

depression than middle-class, White women. To understand whether homelessness, poverty, and other associated adversities will affect an intervention's effectiveness, researchers should include in their study samples groups of homeless families, low-income families, and higher income families. Ideally, samples of higher-income families should be similar in race/ethnicity and marital status to samples of homeless and low-income families, although this may not be feasible, given the associations among race/ethnicity, marital status, and SES.

### **Limitations of this Review**

This review has several limitations. Much of the existing literature on interventions with homeless families has focused on group interventions with adults (e.g., parenting groups). Limiting the review to interventions that included the child in the intervention therefore excluded most RCTs that have been conducted in homeless shelters or transitional housing. The literature on mental health interventions that have been implemented with young homeless children and their mothers is sparse. The studies that exist have discussed interventions within the context of larger, multi-faceted programs (Donlon et al., 2014) or have described pilot programs with limited information on outcomes (Bennett et al., 2006). Due to the limited research available on mental health interventions with young homeless children, I primarily searched the CEBC when selecting interventions for review; as noted in Chapter V, the CEBC is a registry for evidence-based practices found effective with children in the child welfare system. While children in the child welfare system and homeless children have many characteristics in common, the interventions that the CEBC lists may not be the most appropriate or effective interventions for young homeless children living in shelters or transitional housing.

Additionally, using attachment theory to conceptualize the mental health problems of young homeless children has limitations. Bowlby, Ainsworth, and Main, the originators of

attachment theory, were middle- or upper-class, White academics. Many of the psychologists who have conducted empirical studies of attachment theory and developed interventions targeting it are also middle-class and White. Attachment theory and attachment-focused interventions may have White, Western academic biases that render them less applicable to the majority of homeless families who are racial/ethnic minorities.

### **The Author's Experiences with Homeless Families and Children**

My interest in homelessness and its effects dates back more than 30 years. In the 1980s, as a recent college graduate, I was deeply disturbed by the increasing numbers of people living on the streets of Boston. Then as now, I believed that housing is a human right, and that a society has a moral obligation to house its people. I wanted to help end homelessness, and chose to pursue that goal by becoming an architect. For years, I designed affordable housing developments for seniors, immigrants and refugees, previously homeless mothers seeking reunification with their children, and low-income families with children. One of the projects I found most compelling was a day center in downtown Seattle for homeless women and their children. Homelessness proved to be a more intractable problem than my 23-year-old self had imagined, but I had a hand in creating housing that prevented or ended homelessness for some families. The most moving part of my work was seeing people move into their new homes, and hearing them talk about what it meant to them to have safe, decent, affordable homes. The realization that I found greater meaning in interacting with people in need of housing than in designing housing for them led me into social work.

During my first-year internship at the Smith College School for Social Work, I volunteered with the organization for which I had designed the day center for homeless families. I became interested in the mental health problems and needs of homeless women and children. I

had been surprised by the number of infants and young children at the day center, and wondered how the experience of homelessness affected them. I began to read the literature, and to think about how I might combine my interests in clinical social work and family homelessness in my thesis.

In my second-year internship at Smith SSW, I worked with children and families at a community mental health agency in Seattle. The children and adolescents with whom I worked ranged in age from 7 to 19 years old. As I got to know my clients, I was surprised to discover that almost half of them had experienced homelessness. My 19-year-old client, a high school senior, was homeless throughout the months we worked together. My clients had experienced many of the types of homelessness described in Chapter II: living in a shelter, living doubled up with relatives or family friends, living in places not meant for human habitation (e.g., a sailboat, a family friend's barn), and living in foster care after having been removed from a homeless mother's care. While my clients had experienced many other stresses and traumas in their young lives, and the relationship between their experiences of homelessness and their emotional and behavioral problems was unclear, being homeless had been a distressing experience for each of them. In this thesis, I chose to focus on young homeless children, whose mental health needs may be less visible than those of older children. However, as I read and thought and wrote, my former clients who had been homeless were often on my mind.

## **Conclusion**

This review and analysis of the literature was conducted to answer the social worker's question: "How can I help?" Specifically, how might a clinical social worker help a distressed, possibly traumatized young child living with her or his mother in a homeless shelter or transitional housing? The data on homeless families in the United States suggest that over one



million children under the age of six may be homeless each year. The existing literature offers considerable information on the numerous risks, stressors, and traumas that homeless families are likely to have experienced. Existing studies also discuss the prevalence of mental health and attachment problems experienced by children and mothers who are homeless or, more commonly, who have the vulnerabilities (e.g., poverty, low maternal education, exposure to maltreatment or IPV) that may lead to homelessness. However, very few studies exist that evaluate mental health interventions, particularly those focused on fostering secure attachment relationships, that have been implemented with homeless young children. This review described five mental health interventions for young children that focus on the mother-child attachment relationship or an attachment relationship that the child and therapist form. Each of them could be implemented, with the adaptations discussed, in homeless shelters or transitional housing.

No young child – no family – should experience the stressors and traumas associated with homelessness and poverty. These experiences can be devastating to a child's psychological wellbeing, and may have effects that last well beyond childhood. While social workers should work to end homelessness and poverty, we also must attend to the needs of young children who are or have been homeless.

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